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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-14.1 Infection Control Program Effective Date: October 22, 2004

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I. **Purpose:** This procedure has been developed to provide knowledge and supplies that should help the health care provider in maintaining an environment that reduces unnecessary exposure to infectious and communicable diseases for offenders and staff.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Exposure Control Plan:** A document that describes staff actions to be taken to eliminate or minimize exposures to pathogens.

B. **Infectious Disease:** A disease caused by an invasion of the body by pathogenic organisms, which subsequently grow and multiply. Some infectious diseases can be classified as contagious diseases or communicable diseases.

C. **Medical Isolation:** Housing in a room separate from other offenders with a separate toilet, hand washing facility, soap, and single-service towels and appropriate accommodations for showering.

D. **Standard Precautions:** A combination of the major features of universal precautions (designed to reduce the risk of transmission of bloodborne pathogens) and body secretion isolation (designed to reduce the transmission of pathogens from moist body substances), applied to all patients receiving care, regardless of diagnosis or presumed infection status.

III. PROCEDURES:

A. Infection control recommendations in the Correctional Medical Services infection control manual for surveillance, containment, testing, decontamination, sterilization and proper disposal of sharps and bio-hazardous wastes should be followed.

B. An exposure control program as outlined in Correctional Medical Services infection control manual should be followed in the event of possible exposure to infectious disease.

1. Each medical unit will develop a written exposure control plan, approved by the medical director/responsible physician to be reviewed and updated annually.

2. Each facility should ensure that:

a. appropriate medical, dental, laboratory equipment and instruments are decontaminated;
b. sharps and biohazardous wastes are disposed of properly;
c. surveillance to detect offenders with serious infectious and communicable disease is effective;
d. immunizations to prevent disease are provided when appropriate;
e. infected patients receive medically indicated care; and
f. if appropriate, offenders with contagious diseases are medically isolated.

C. Standard precautions will be used by health care staff to minimize the risk of exposure to blood and body fluids of infected patients.

D. Health staff sanitation workers will be trained in appropriate methods for handling and disposing of biohazardous materials and spills.

E. Active tuberculosis patients will be housed in designated negative pressure rooms.

F. The health service staff will ensure that offenders who are released with communicable diseases are provided community referrals.

G. An infection control committee should be established as a subcommittee to the quality improvement committee of each medical unit.

1. Written reports by the health service administrator or designee should identify reportable diseases, outbreaks, occurrences of infectious diseases, and problem-solving opportunities.

H. The health services administrator/designee should complete and file all reports consistently with local, state, and federal laws and regulations.

1. Annual statistics should be maintained by the health service administrator or designee by monthly completion of the Monthly Infection Control Report format (Attachment A).

a. Disease case reporting to the department of health and senior services should be done using the Disease Case Report (Attachment B).

I. The health service administrator/director of nursing or designated infection control nurse should monitor employees knowledge of infection control and exposure control annually on a formal basis, and more often if problems are identified.

J. The medical director and health services administrator should implement the pertinent sections of the Correctional Medical Service infection control manual regarding employee safety.

K. The Correctional Medical Service regional infection control nurse, regional medical director, superintendent, and division director of offender rehabilitative services should be notified and informed of any outbreaks of disease.

IV. ATTACHMENTS

A.		Monthly Infection Control Report - Format
B.	580-0779	Disease Case Report

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-B-01 Infection Control Program – *essential.*
B. IS11-14.2 Tuberculosis Control
C. IS11-14.3 Communicable Disease Isolation
D. IS11-14.4 HIV Infected Offenders
E. IS11-14.7 Exposure Control Plan-Bloodborne Pathogens
F. CMS Infection Control Manual

VI. HISTORY: This procedure was originally covered by IS11-14.1 Infection Control Program Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994

A.	Original Effective Date:	August 15, 1994
B.	Revised Effective Date:	October 15, 1999
C.	Revised Effective Date	

ATTACHMENT A

Monthly Infection Control Report - Missouri

Facility:	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03	2003 Totals
HIV													
Total number of offenders receiving Pre-test counseling													
Total number of offenders receiving Post-test counseling													
Total number of CMS employees receiving HIV education													
Total number of offenders receiving HIV education													
Total number of offenders referred to DHSS for Level II intervention													
Total number of HIV tests drawn													
Total number of newly diagnosed HIV carriers upon entrance draws													
Total number of newly diagnosed HIV carriers (field to be eliminated in new report)													
Total number of newly diagnosed HIV carriers upon non-entrance/non-exit draws													
Total number of newly diagnosed HIV carriers upon exit draws													
Total number of HIV carriers transferred into facility													
Total number of HIV carriers released from DOC													
Total number HIV carriers at facility													
Total number of offenders newly diagnosed having full-blown AIDS (CD4<200 or + AIDS defining illnesses)													
Total number of offenders with AIDS released from DOC													
Total number of AIDS offenders													
Total number of offenders with absolute CD4 count <500													
Total number of offenders with absolute CD4 <200													
Total number of HIV+ offenders on HIV meds													
Total number of HIV+ offenders on Interruption Therapy													
Total number of HIV+ offenders not on HIV meds/therapy													
TB													
Total number of PPD tests given													
Total number of reactions 0mms													
Total number of reactions 1-4mms													
Total number of reactions 5-9mms													
Total number of reactions 10-15mms													
Total number of reactions >15mms													
Total number of reported hx of +PPD's interviewed for presence of symptoms													
Total number of refusals													
Total number of HIV- offenders placed on TB prophylaxis													
Total number of HIV+ offenders placed on TB prophylaxis													
Total number of past reactions placed on TB prophylaxis													
Total number of offenders on INH medication													
Total number of offenders on other anti-tubercular medications													
Total number of offenders on anti-tubercular therapy													
Total number of offenders that completed TB therapy													
Total number of offenders released from DOC on TB prophylaxis													
Total number of offenders placed in Respiratory Isolation from facility													
Total number of offenders released or returned from Respiratory Isolation from facility													
Total number of offenders diagnosed with active TB													
Hepatitis													
Total number of newly diagnosed acute Hepatitis A													
Total number of newly diagnosed acute Hepatitis B													
Total number of newly diagnosed Hepatitis B carriers													
Total number of newly diagnosed acute Hepatitis C													
Total number of newly diagnosed Hepatitis C carriers													
Current number of offenders in Hepatitis C Chronic Care													
Total number of offenders started on Interferon therapy for Hepatitis C													
Total number of offenders receiving Interferon therapy for Hepatitis C													
Other Infectious Diseases													
Total number of newly diagnosed Gonorrhea cases													
Total number of newly diagnosed syphilis cases													
Total number of newly diagnosed chlamydia cases													
Total number of other newly diagnosed STDs													
Total number of newly diagnosed Scabies cases													
Total number of newly diagnosed pediculosis (lice) cases													
Total number of newly diagnosed influenza (flu) cases													
Total number of newly diagnosed chicken pox (varicella) cases													
Total number of newly diagnosed shingles (latent varicella) cases													
Total number of newly diagnosed other infectious diseases													
Exposures													
Total number of medical staff exposures													
Total number of offender exposures													
Total number of reported DOC exposures													
Total number of laboratory tests drawn for medical staff exposures													
Total number of laboratory tests drawn for offender exposures													
Total number of laboratory tests drawn for DOC exposures													
Total number of laboratory test refusals for exposures													

Updated 09/2002

Non-Entrance/Non-Exit HIV draws include voluntary testing, court mandated testing, exposure testing, etc.
Number of HIV+ offenders not on HIV meds DOES NOT include those on Interruption Therapy.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

DISEASE CASE REPORT

REPORT TO LOCAL PUBLIC HEALTH AGENCY

1 DATE OF REPORT ___/___/___	2 DATE RECEIVED BY LOCAL HEALTH AGENCY ___/___/___

3 NAME (LAST, FIRST, M.I.)	4 GENDER ☐ MALE ☐ FEMALE	5 DATE OF BIRTH ___/___/___	6 AGE	7 HISPANIC ☐ YES ☐ NO ☐ UNKNOWN

8 RACE (CHECK ALL THAT APPLY) ☐ BLACK ☐ ASIAN ☐ PACIFIC ISLANDER ☐ WHITE ☐ AMERICAN INDIAN ☐ UNKNOWN	9 PATIENT'S COUNTRY OF ORIGIN	10 DATE ARRIVED IN USA ___/___/___
11 ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	12 COUNTY OF RESIDENCE	13 TELEPHONE NUMBER ( )
14 PREGNANT ☐ YES (IF YES NUMBER OF WEEKS ____) ☐ NO ☐ UNKNOWN	15 PARENT OR GUARDIAN	16 RECENT TRAVEL OUTSIDE OF MISSOURI OR USA ☐ YES ☐ NO IF YES, WHERE ____	17 DATE OF RETURN ___/___/___
18 OCCUPATION	19 SCHOOL/DAY CARE/WORKPLACE ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	

20 WORK TELEPHONE NUMBER ( )	21 OTHER ASSOCIATED CASES ☐ YES ☐ NO ☐ UNKNOWN IS REPORT PART OF AN OUTBREAK ☐ YES ☐ NO ☐ UNKNOWN	22 TYPE OF COMPLAINT/OUTBREAK ☐ FOODBORNE ☐ WATERBORNE ☐ OTHER (SPECIFY) ____

23 WAS PATIENT HOSPITALIZED ☐ YES ☐ NO ☐ UNKNOWN	24 PATIENT RESIDE IN NURSING HOME ☐ YES ☐ NO ☐ UNKNOWN	25 PATIENT DIED OF THIS ILLNESS ☐ YES ☐ NO ☐ UNKNOWN

26 CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD):	PATIENT YES	PATIENT NO	PATIENT UNK	HHLD MEMBER YES	HHLD MEMBER NO	HHLD MEMBER UNK
26 A FOOD HANDLER						
ATTENDS OR WORKS AT A CHILD OR ADULT DAY CARE CENTER						
26 A HEALTH CARE WORKER						

27 NAME OF HOSPITAL/NURSING HOME	
28 HOSPITAL/NURSING HOME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	
29 REPORTER NAME	30 TELEPHONE NUMBER ( )
31 REPORTER ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	32 TYPE OF REPORTER/SUBMITTER ☐ PHYSICIAN ☐ OUTPATIENT CLINIC ☐ PUBLIC HEALTH CLINIC ☐ HOSPITAL ☐ LABORATORY ☐ SCHOOL ☐ OTHER ____
33 ATTENDING PHYSICIAN/CLINIC NAME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	34 TELEPHONE NUMBER ( )

35 DISEASE NAME(S)	36 ONSET DATE(S) ___/___/___ ___/___/___	37 DIAGNOSIS DATE(S) ___/___/___ ___/___/___	38 DISEASE STAGE/ RISK FACTOR	39 PREVIOUS DISEASE/STAGE	40 PREVIOUS DISEASE DATE(S) ___/___/___ ___/___/___

41 - DIAGNOSTICS

TEST DATE (MO/DAY/YR)	TYPE OF TEST	SPECIMEN TYPE	COLLECTION DATE (MO/DAY/YR)	QUALITATIVE / QUANTITATIVE RESULTS	REFERENCE RANGE	LABORATORY NAME/ADDRESS (INCLUDE STREET OR RFD, CITY, STATE, ZIP CODE)

42 - TREATMENTS

TREATED (Y/N/UNK)	REASON NOT TREATED	TYPE OF TREATMENT	DRUG	DOSAGE	TREATMENT DATE (MO/DAY/YR)	TREATMENT DURATION (IN DAYS)	PREVIOUS TREATMENT	PREVIOUS LOCATION (LIST CITY, STATE)

43 - SYMPTOMS

SYMPTOM (IF APPLICABLE)	SYMPTOM SITE (IF APPLICABLE)	SYMPTOM ONSET DATE (MO/DAY/YR)	SYMPTOM DURATION (IN DAYS)

44 COMMENTS

NOTES FOR ALL RELEVANT SECTIONS:

- Stages, risk factors, diagnostics, treatments, and symptoms shown below are examples. To see a more complete listing, please go to ***http://www.dhss.state.mo.us/Diseases/DDwelcome.htm.*** You may also contact the Office of Surveillance at 1-800-392-0272 for additional information or to report a case.
- All dates should be in Mo/Day/Year (01/01/2001) format.
- All complete addresses should include city, state and zip code.
- Required fields referenced below are italicized and bold, however fill form as complete as possible.

(1) Date of Report -- date sent by submitter of document.

(2) Date received will be filled in by receiving agency.

(3-8) **CASE DEMOGRAPHICS/IDENTIFIERS:** ***Last name, First Name,*** Gender, ***Date of Birth,*** Hispanic, Race - please check all that apply

(23) Was patient hospitalized due to this illness?

(32) Type of reporter/submitter (doctor, nursing home, hospital, laboratory) (33-34) Attending physician or clinic (full physician name and degree, address, phone)

DISEASE: ***(35) Disease name or name(s), (36) Onset date(s), (37) Diagnosis Date(s)***

(38) Disease Stage or Risk Factor

Syphilis
Primary (chancre present)
Secondary (skin lesions, rash)
Early Latent (asymptomatic < 1 year)
Late Latent (over 1 year duration)
Neurosyphilis
Cardiovascular
Congenital
Other

Gonorrhea or Chlamydia
Asymptomatic
Uncomplicated urogenital (urethritis, cervicitis)
Salpingitis (PID)
Ophthalmia/conjunctivitis
Other (arthritis, skin lesions, etc)

TB Infection
Contact to TB case
Immunocompromised
Abnormal CXR
Foreigner/Immigrant
IV Drug/Alcohol Abuse
Resident, correctional
Employee, correctional
Over 70
Homeless
Diabetes
Healthcare worker
Converter/2 yrs ≥ 10
Converter/2 yrs ≥ 15

(39) Previous Disease/Stage (if applicable) ***(40) Previous Disease Dates (if applicable)***

(41) Diagnostics (Please Attach Lab Slip)

Test Type

Hepatitis
Igm Anti-HBc
Anti-HBs
Anti-HBc Total
Igm Anti-HAV
HBsAg
Hep C

TB
Not Done
Mantoux
Multiple puncture device
X-Ray
Smear
Culture

Other
Elisa
Western Blot
Culture
ALT
AST

Specimen Type (blood, urine, CSF, smear, swab), **Collection Date** (Mo/Day/Yr), **Qualitative** (negative, positive, reactive), **Quantitative Results** (1:1, 2.0 mm reading,) **Reference Range** (1:1neg, 1:64 equivocal, 1:128 positive, > 2 positive), **Laboratory** (name, address)

(42) TREATMENT

Reason not treated
False positive
Previous treated
Age

Drug
TB
Isoniazid
Ethambutol
Pyrazinamide
Rifampin

(43) SYMPTOMS:
Symptom (jaundice, fever, dark urine, headache) **Symptom Site** (head, liver, lungs, skin), **Symptom Onset Date** (Mo/Day/Yr) and **Symptom Duration** (in days)

(44) **Comments:** Attach additional sheets if more comments needed.

CD-1

MO 580-0779 (9-01)

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-15.1 Disposal of Biohazardous Waste

Effective Date: January 23, 2006

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Randee Kaiser, Director
Division of Offender Rehabilitative Services

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I. **Purpose:** This procedure has been developed to ensure that all clinics, infirmaries/transitional care units/ institutions dispose of infectious waste in a proper manner compliant with Missouri Department of Health and Missouri Department of Natural Resource's regulations. The proper disposal of infectious waste protects offenders, staff, and the community from exposure to potentially hazardous disease.

A. **AUTHORITY:** 217.175, 217.320 RSMo, National Commission on Correctional Health Care Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Biohazardous Container:** An approved puncture resistant and leak-proof container labeled with a biohazard symbol or color-coded red.

B. **Biohazardous Waste:** Biohazardous waste is also referred to as regulated, infective, infectious, and medical waste. OSHA defines biohazardous waste as:

1. any liquid or semi-liquid blood or other potentially infectious materials;
2. contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed;
3. items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling;

4. sharps (includes needles, scalpel blades, glass, pipettes) contaminated with blood and/or body fluids; and
5. pathological and microbiological wastes containing blood or other potentially infection materials.

III. PROCEDURES:

A. The health services administrator at each institution shall be responsible for ensuring the isolation and identification of biohazardous/regulated waste from all other health services waste at the point of generation.

1. Caution will be taken to preclude any staff or offender theft, abuse, and contact with such products.

2. All infectious waste containers shall be identified with the Universal Biological Hazard Symbol (Attachment A).

3. The health services administrator shall be responsible for ensuring an adequate supply of the biological hazard symbols is readily available at all times.

B. All infectious waste shall be placed in approved containers.

1. Patient care areas will have red plastic-lined receptacles available for disposal of contaminated dressings and other items.

2. Receptacles for contaminated items preferably have a foot-operated lid will be emptied by the clinic staff nurse as needed and daily.

   a. Used red plastic liners will be closed prior to removal and will be placed in a second red plastic liner if necessary to prevent spillage or protrusion of contents during handling, storage, and transport.

   b. Biohazardous waste items will be placed in the container supplied by the biohazardous waste removal contractor.

      1. This container will be closable, leak proof, and labeled.

C. All sharps shall be placed in approved containers.

1. Used sharps and other miscellaneous items, which have the potential to puncture plastic bags and cardboard boxes, will be placed in red puncture-resistant rigid containers at the point of use.

2. Sharps containers will be secured in a manner; such as attachment to the wall, to prevent tampering with and possible injury of offenders and to maintain upright position.

3. Sharps containers will not be filled more than 2/3 full to prevent injury.

4. Used sharps containers will be closed and sealed immediately prior to handling by any staff member and placed in the container supplied by the biohazardous waste removal contractor (a rigid box with leak-proof liner and biohazardous labeling).

5. Used sharps containers will be placed in a secondary closable, leak proof, labeled container if leakage is possible during handling.

D. Storage of biohazardous waste containers shall be as follows until the contractor can remove the containers from the institution.

1. The storage area for biohazardous waste awaiting pick-up must be a secured area with limited access. Remember, this is waste – do not store in clean areas, i.e., pharmacy, clean storage area, etc.

2. The room must be designated and marked as containing biohazardous material.

3. Biohazardous waste awaiting removal from the facility must be stored in red plastic bags inside a rigid, sealed, labeled container supplied by the contract vendor.

4. Boxes should not be stored directly on the floor.

E. Biohazardous waste must be removed from the facility on a regular basis. Removal should be scheduled at least weekly if stored biohazardous waste consists of more than sharps.

F. Manifests from the contracted company that removes biohazardous waste must be maintained.

1. The health services administrator will maintain copies of the manifest.

2. The manifest must state when and what was removed, the location and date of disposal.

3. The site receives the bottom copy when the waste is taken out of the facility .

4. The health services administrator will obtain a confirmation from the contracted vendor that states when and where the waste occurred for disposal of the biohazardous waste.

5. The health service administrator will obtain a copy of the confirmation through an accessed internet service.

G. The contracted company that removes biohazardous waste should provide a copy of the permit to do business, name of disposal site, and certificate of insurance.

H. Offender workers are not allowed to dispose of biohazardous containers or biohazardous waste.

IV. ATTACHMENTS

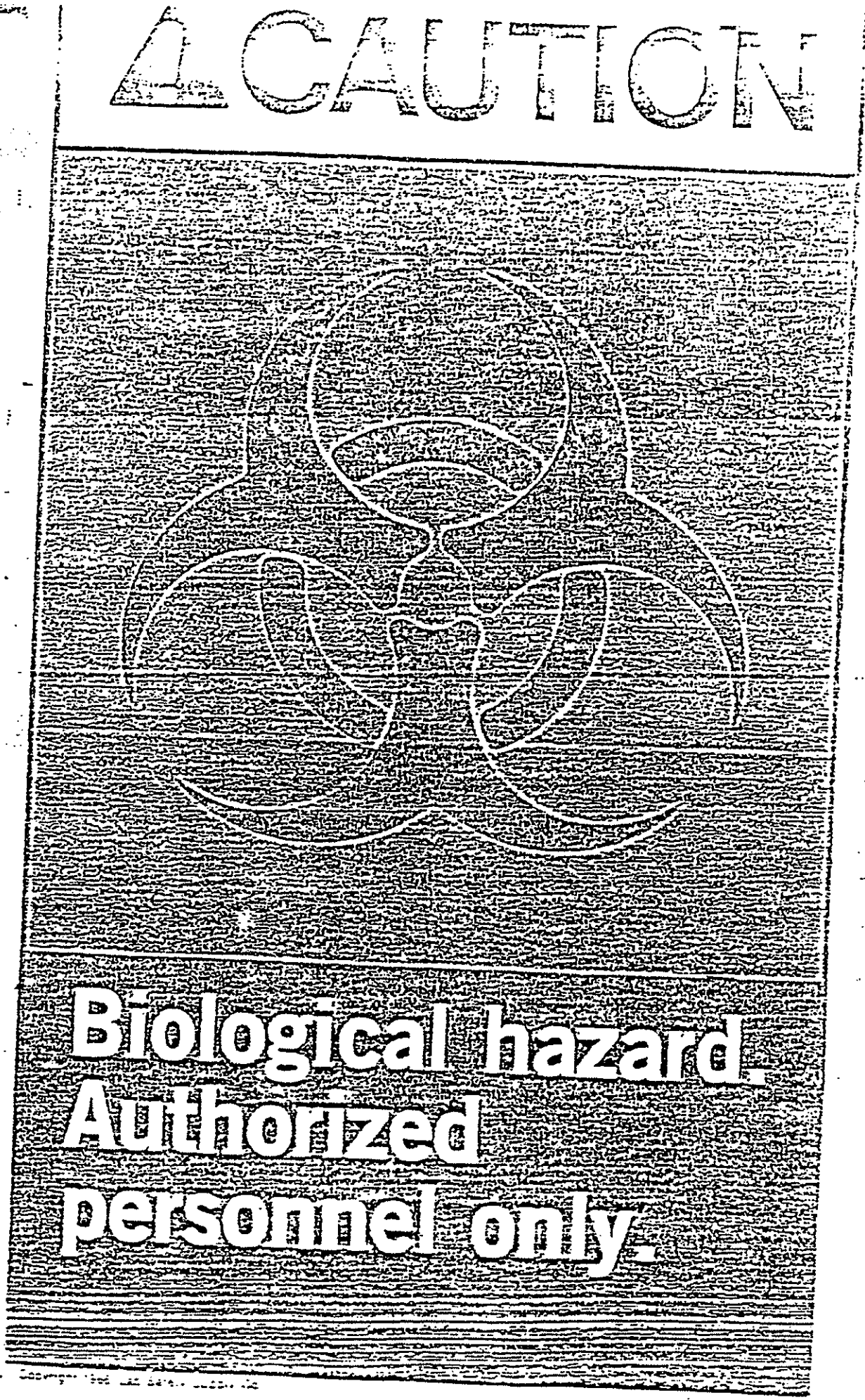
A. Universal Biohazardous Symbol

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-B-02 Environmental Health and Safety – *essential,* P-B-01 Infection Control – *essential.* APIC (Association for Professional in Infection Control and Epidemiology, INC) Text of Infection Control and Epidemiology, Volume 2, ENVIRONMENTAL SERVICES, 73-5, 73-6.

VI. HISTORY: Not previously covered by division rules. This procedure number was previously IS11-3.6 Disposal of Infectious and Innocuous Waste until February 1, 1995, and revised as procedure number IS11-15.2, Disposal of Infectious and Innocuous Waste the revised October 15, 1999 as IS11-15.1, Disposal of Regulated Waste located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual.

A.	Original Effective Date:	March 1, 1992
B.	Revised Effective Date:	February 1, 1995
C.	Revised Effective Date:	November 4, 1998
D.	Revised Effective Date:	October 15, 1999
E.	Revised Effective Date:	January 23, 2006


CAUTION
Biological hazard.
Authorized
personnel only.

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-14.6 HIV Testing for Offenders Effective Date: **January 23, 2006**

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Division of Offender Rehabilitative Services

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I. **Purpose:** This procedure has been developed to ensure testing guidelines for all offenders within a correctional center or institutional treatment center to meet their medical needs regarding HIV/AIDS.

A. **AUTHORITY:** 217.175, 217.320, 191.659 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **AIDS:** Acquired Immune Deficiency Syndrome (AIDS): A medical condition caused by the Human Immunodeficiency Virus (HIV) which results in the destruction of the body's natural defenses against disease and is characterized by certain medical conditions as defined by the Center for Disease Control and Prevention (CDC) and American Medical Association (AMA).

B. **Body Fluids:** Any fluid or substance produced within the human body.

1. Blood and body fluids requiring standard precautions are:

a. blood (including menstrual blood),
b. seminal fluid, vaginal secretions,
c. amniotic (pregnancy) fluid,
d. cerebrospinal (brain and backbone) fluid,
e. synovial (joint) fluid,
f. pleural (chest) fluid, and

g. saliva in the dental setting (due to the bloody nature of such).
h. Most body fluids are locked inside the joints and body cavities and when they are released due to injury, they will usually be mixed with blood.

2. Body fluids not requiring standard precautions unless visible blood is present include feces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomit.

C. **ELISA (Enzyme-Linked Immunosorbent Agent):** The initial laboratory test procedure used to detect HIV antibodies in the blood: results are either positive or negative.

D. **Equivocal Test Result:** Western blot test results that are neither positive nor negative, thus requiring re-testing as there exists a high possibility of positive HIV.

E. **HIV Positive:** Infection with the human immunodeficiency virus.

F. **HIV Related Illness:** Infection with HIV and some, but not all, of the symptoms of AIDS. Infections and symptoms may be successfully treated, but damage to the immune system is permanent.

G. **Inconclusive Test Result:** The initial ELISA test is positive and the confirmatory Western Blot test is negative. Follow-up testing is indicated in these cases.

H. **Medical Accountability Record System (MARS):** The electronic medical record system utilized by the Missouri Department of Corrections.

I. **Standard Precautions:** A combination of the major features (use of protective barriers such as gloves, gowns, aprons, masks, or protective eyewear to reduce risk of exposure of skin or mucous membranes) of universal precautions (designed to reduce the risk of transmission of bloodborne pathogens) and body secretion isolation (designed to reduce the transmission of pathogens from moist body substances), applied to all patients receiving care, regardless of diagnosis or presumed infection status.

J. **Testing:**

1. **Voluntary Testing:** Testing requested by the offender, no more than one time per year.

2. **Mandatory Testing:** The requirement to submit to an HIV test either willingly or by use of force, as directed by statute or court order.

3. **High Risk Exposure:** An incident involving exposure to blood, semen, or body fluids to which standard precautions apply through another's eye, mouth, laceration, or non-intact skin. A needle stick puncture or incision if it occurs with instruments that are soiled with an above noted fluid.

4. **High Risk Behavior:** An incident of behavior, which suggests the possibility of exposure to infection to include but not, limited to:

a. sexual contact that involves the exchanges of body fluids to which standard precautions apply;
b. injection drug use;
c. possession of needles or syringes;
d. tattooing and piercing of a body part; and,

e. involvement in an incident where one's blood is exposed to another person. The person exposed may be staff or offender.

5. **Symptomatic Testing:** Testing for HIV based on display of medical signs, indications, or symptoms of HIV related illness or AIDS.

6. **Western Blot:** Laboratory confirmation blood test procedure with results positive, negative or equivocal.

III. PROCEDURES:

A. Confidentiality

1. Departmental health care staff, and others as established in this procedure, will be provided with information relating to the HIV sero status of offenders.

2. Information will not be shared unless the offender has provided express written consent on their specific HIV serum result status.

3. The consent shall specifically authorize release of HIV test results and to whom the test results will be released.

4. The test results will not be released with a routine release of medical records.

5. Employees who breach confidentiality shall be subject to discipline.

B. Standard Precautions

1. All persons must be considered to be potentially infected as the virus may be dormant in individuals tested and not appear when the HIV antibody test is performed.

2. Body fluids to which standard precautions apply should be handled with protective equipment.

C. General Testing Procedures

1. In all cases where testing is performed, health care staff shall document the reason the test is being conducted and the date of the test on the inside of the offender's medical record.

2. Offenders refusing entry or exit mandatory testing will be immediately placed in temporary administrative segregation confinement in accordance with IS21-1.1 Temporary Administrative Segregation Confinement.

   a. The health service administrator/designee will submit a memorandum to the superintendent stating the offender refused the required HIV testing.

   b. The superintendent/designee will assign appropriate staff to write a conduct violation for disobeying an order.

c. After 24 hours of segregation (or less if testing is needed for exit HIV), force may be used while medical staff obtain the test in accordance with IS20-3; Use of Force Guidelines and IS21-1.1 Temporary Administrative Segregation Confinement.

3. Health care staff shall be responsible for conducting all HIV testing and necessary blood sampling procedures and will document the results on the HIV Antibody Test Form (Attachment A) and or within the medical accountability record system.

4. Should medical staff be unable to obtain a mandatory test specimen, the offender will be transported to a local hospital in accordance with IS11-30 Hospital and Specialized Ambulatory Care.

a. A lab transport approved container will be used for transportation of the blood specimen back to the health care unit.

D. Types of Tests

1. Entry Testing

a. All newly committed offenders and offenders returned for incarceration, except those known to be HIV seropositive from prior commitment, or those reporting to a diagnostic center with positive test results documented and obtained subsequent to trial and prior to incarceration, shall be required to submit to HIV testing performed at the receiving diagnostic center.

2. High Risk Testing

a. Any staff witness to a high-risk exposure incident will report the incident to the superintendent/designee in writing.

1. The superintendent will notify the health services administrator/designee.

2. The health services administrator/designee shall determine the need for testing.

3. A copy of the report will be placed in the offender's medical record.

4. The superintendent/designee will copy the violation report to the health services administrator/designee who shall determine the need for testing.

5. A copy of the violation will be placed in the health care office, infection control HIV risk testing file.

b. HIV tests drawn for high-risk blood or body fluid exposures:

1. Blood shall be drawn by a nurse within 24 hours of reported exposure;

2. The lab requisition will be identified as "Exposure Testing – Run ASAP";

3. A telephone call will be made by the sending nurse as designated by the physician/designee to the lab notifying the lab that the specimen is being sent due to an exposure.

a. The lab may be either FRDC, a local hospital or contract provider lab.

4. The specimen should be sent to FRDC.

a. If the exposure and resulting lab test occurs on a Monday and the regular courier does not make routine transport until a Thursday – then special arrangements MUST BE made to deliver the specimen.

c. The offender or staff member exposed to high-risk blood or body fluids should be started on post exposure prophylaxix (PEP) medications as determined by the treating physician, pending results of the HIV status report.

d. When a state employee exposure occurs by an offender, the offender may receive rapid testing at a local hospital if the offender had not previously proven to be HIV positive and a true high-risk exposure occurred.

3. Scheduling

a. Upon determination of need, the health services administrator/designee shall schedule testing.

b. Medical staff shall document in the medical accountability record system the date and time the test was drawn.

4. High Risk Behavior and High Risk Exposure

a. Upon determining the need for testing following high risk behavior or exposure, the offender(s) involved in the behavior or incident will be tested at intervals recommended by the Centers for Disease Control and Prevention (CDC).

b. When an HIV positive offender exhibits high-risk behavior, the health services administrator/designee will refer name and required identifying information to the department of health for possible intervention.

5. Voluntary Testing

a. An offender may submit a written request for voluntary testing to the medical unit by completing a Medical Services Request Form (Attachment F).

b. Voluntary testing will be performed no more than one time per year.

c. Evaluation of voluntary requests will be made by the infection control nurse during offender counseling.

d. Determination of need for testing and follow-up will be made in consultation with the physician.

6. Exit Testing

a. Exit testing will be conducted no sooner than 120 days prior to release.

b. The records officer will notify the medical unit of offenders being released as soon as she/he is notified.

c. Upon notification of the offender's release date, the health services administrator/designee should schedule testing within 3 working days.

d. Where positive test results are discovered, the health services administrator/designee shall notify in writing the institutional parole office supervisor/designee, who shall in turn notify the probation and parole supervisor where the home plan exists.

1. Upon notification that an offender is HIV positive, the supervising probation and parole officer will have the offender sign the Medical Information Release Authorization Form (Attachment C).

a. The release of information will be forwarded to the district office where the offender's home plan exists.

2. When the offender is released prior to the receipt of test results, and she/he has not received post-test counseling, medical staff will make a referral to the Bureau of HIV/STD Prevention by way of written or telephone communication.

a. Referral to the Bureau of HIV/STD Prevention referral notification will be documented by the infection control nurse/designee in the offender medical accountability record system.

E. Test Results

1. All HIV tests will be submitted to the health services unit lab at Fulton Reception and Diagnostic Center.

a. Negative Test Results

1. The Fulton Reception and Diagnostic Center lab clerk will send a notification letter and test results to the health services administrator/designee.

2. The health services administrator/designee will call the offender to the medical unit and notify the offender verbally of the test results, answer any questions the offender may have, counsel the offender and ensure that the offender understands the test result.

3. The health services administrator/designee will have the offender date and sign the letter of notification and the health services administrator/designee will co-sign the letter.

4. If the offender refuses to sign the letter, the health services administrator/designee and a witness will sign the letter indicating the offender's refusal.

5. The letter will be filed by the medical staff records clerk in the offender's medical record under the diagnostic test section.

2. Inconclusive Test Results

   a. The Fulton Reception and Diagnostic Center lab clerk will send the test results and notification letter to the health services administrator/designee.

   b. The health services administrator/designee will call the offender to the medical unit and notify the offender verbally of the test results, answer any questions the offender may have, counsel the offender, and ensure that the offender understands the test result.

   c. The health services administrator/designee will have the offender date and sign the letter of notification and the health services administrator/designee will co-sign the letter.

   d. If the offender refuses to sign the letter, the health services administrator/designee and another health staff member or custody staff as witness will sign the letter indicating the offender's refusal.

   e. The letter will be filed in the offender's medical record under the diagnostic test section.

   f. The test will be repeated in 30 days.

      1. If negative at 30 days then further scheduled testing will not be needed.

      2. If other than negative, follow appropriate test result guidelines.

3. Equivocal Test Results

   a. The Fulton Reception and Diagnostic Center lab clerk will send the notification letter and test results to the health services administrator/designee.

   b. The health services administrator/designee will call the offender to the medical unit and notify the offender verbally of the test results, answer any questions the offender may have, counsel the offender, and ensure that the offender understands the test result.

   c. The health services administrator/designee will have the offender date and sign the letter of notification and the health services administrator/designee will co-sign the letter.

   d. If the offender refuses to sign the letter, the health services administrator/designee and a witness will sign the letter indicating the offender's refusal.

   e. The letter will be filed in the offender's medical record under the diagnostic test section.

   f. The test will be repeated in 30 days and:

      1. if negative at 30 days it will be repeated;
      2. if remains equivocal after first 30 days, repeat at 60 days, then every 6 months until a negative or positive test is obtained;

3. and if it is positive at 30 days, no repeat testing is necessary.

4. Positive Test Results

a. The health services administrator/designee will notify the department of health via telephone followed by sending the completed Physician's Confidential Report of HIV Infection form (Attachment B).

b. The Fulton Reception and Diagnostic Center lab clerk will send a notification letter and test results to the health services administrator/designee.

c. The health services administrator/designee will call the offender to the medical unit and notify the offender verbally of the test results, answer any questions the offender may have, counsel the offender and ensure that the offender understands the test result.

d. The health services administrator/designee will have the offender date and sign the letter of notification and the health services administrator/designee will co-sign the letter.

e. If the offender refuses to sign the letter, the health services administrator/designee and a witness will sign the letter indicating the offender's refusal.

f. The letter will be filed in the offender's medical record under the diagnostic test section.

g. The health services administrator/designee will notify the assistant division director of offender rehabilitative services of the positive result of any offender convicted of a sexual offense or the offense of infecting another with the potential for HIV infection.

h. The assistant division director of offender rehabilitative services will contact the victims services coordinator/designee to obtain information regarding the names, addresses and telephone number of victims.

i. The assistant division director of offender rehabilitative services will provide this information to the department of health so they can notify the victim.

j. All offenders who test positive shall be offered or referred to the mental health professional for counseling.

1. This will be documented in the medical file.

k. All offenders will be enrolled in the appropriate chronic care clinic.

5. Copies of HIV test results will not be provided to offenders while they are incarcerated.

a. Copies of HIV results may be sent outside of the institution if so requested and with a signed release of information by the offender in compliance with release of confidential medical information and medical record copying as outlined in IS11-61, Confidentiality of Health Records and Health Information.

b. A copy may be given to the offender on the day of release from the department.

6. All results should be posted in the MARS – Medical Accountability Record System (computerized medical record).

7. All lab testing will be conducted by a certified lab technician with oversight by the lab pathologist.

8. Positive, equivocal, or inconclusive HIV test results should be entered by the lab technician or licensed health care professional.

9. The Correctional Medical Services Referral To Positive Start Transitional Case Management form (Attachment K) will be completed by the health services administrator/designee on offenders testing positive for HIV.

a. The form will be completed at the offender's assigned facility and each concurrent facility reassignment of the offender.

b. The form will be faxed to the Department of Health and Senior Services as stated on the form.

F. AIDS Reporting

1. When the offender's condition meets criteria for "AIDS" diagnosis determined by the Centers for Disease Control (CDC), an Adult HIV/AIDS Confidential Case Report, (Attachment L) should be completed and sent to the department of health and bureau of HIV/STD prevention.

IV. ATTACHMENTS

A.	931-3345	HIV Antibody Test (DOC)
B.	931-1319	Medical Services Request
C.	931-3553	Medical Information Release Authorization
D.	931-3761	Negative HIV Test Results
E.	931-4212	Inconclusive HIV Test Results
F.	931-4213	Equivocal HIV Test Results
G.	580-1641	Physician's Confidential Report of HIV Infection
H.	931-4033	HIV/AIDS Summary Treatment Record
I.	931-4180	HIV Infection Status Notification
J.	931-4211	Positive HIV Test Results
K.		Correctional Medical Services Referral To Positive Start Transitional Case Management
L.	CDC50.42A	Adult HIV/AIDS Confidential Case Report

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-B-01 Infection Control Program – *essential*, P-H-02 Confidentiality of Health Record Information - *essential*.
B. IS11-14.4 HIV Infected Offenders
C. IS11-61Confidentiality of Health Records and Health Information
D. IS20-3 Use of Force
E. IS21-1.1 Temporary Administrative Segregation Confinement

VI. HISTORY: This policy was originally covered by D5-5.2 HIV/AIDS; Original Rule Effective: September 15, 1993.

A. Original Effective Date: October 15, 1999

B. Revised Effective Date: January 23, 2006

ATTACHMENT A

PATIENT ID NUMBER | DATE DRAWN

ST) | FIRST

JTION | DATE OF BIRTH | RACE | SEX | TEST CODE

DRAWN BY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated

REMARKS

RETURN RESULTS TO THE OFFICE OF H.E.C. DEPARTMENT OF CORRECTIONS.

O 931-3345 (4-93) **DISTRIBUTION:** **WHITE** - DEPARTMENT OF CORRECTIONS; **CANARY** - LAB

SPACE BELOW FOR LABORATORY USE

LAB SERIAL NUMBER

TEST PERFORMED	N	E	R
ELISA			

Risk:

- ☐ Homo/Bisexual
- ☐ Blood Recipient
- ☐ Heterosexual
- ☐ Prostitute
- ☐ Multiple Partners
- ☐ Sex Partners of Person at Risk
- ☐ Exposure Incident
- ☐ Other (specify) _____
- ☐ IV Drug User
- ☐ Hemophiliac
- ☐ Perinatal
- ☐ Tattoo
- ☐ Unknown

IV ANTIBODY TEST (DOC)

ATIENT ID NUMBER | DATE DRAWN

AME (LAST) | FIRST

ISTITUTION | DATE OF BIRTH | RACE | SEX | TEST CODE

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated

M.

ETURN RESULTS TO THE OFFICE OF H.E.C. DEPARTMENT OF CORRECTIONS.

931-3345 (4-93) **DISTRIBUTION:** **WHITE** - DEPARTMENT OF CORRECTIONS; **CANARY** - LAB

SPACE BELOW FOR LABORATORY USE

LAB SERIAL NUMBER

TEST PERFORMED	N	E	R
ELISA			

Risk:

- ☐ Homo/Bisexual
- ☐ Blood Recipient
- ☐ Heterosexual
- ☐ Prostitute
- ☐ Multiple Partners
- ☐ Sex Partners of Person at Risk
- ☐ Exposure Incident
- ☐ Other (specify) _____
- ☐ IV Drug User
- ☐ Hemophiliac
- ☐ Perinatal
- ☐ Tattoo
- ☐ Unknown

/ ANTIBODY TEST (DOC)

IENT ID NUMBER | DATE DRAWN

IE (LAST) | FIRST

ITUTION | DATE OF BIRTH | RACE | SEX | TEST CODE

WN BY

ital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated

URN RESULTS TO THE OFFICE OF H.E.C. DEPARTMENT OF CORRECTIONS.

-3345 (4-93) **DISTRIBUTION:** **WHITE** - DEPARTMENT OF CORRECTIONS; **CANARY** - LAB

SPACE BELOW FOR LABORATORY USE

LAB SERIAL NUMBER

TEST PERFORMED	N	E	R
ELISA			

Risk:

- ☐ Homo/Bisexual
- ☐ Blood Recipient
- ☐ Heterosexual
- ☐ Prostitute
- ☐ Multiple Partners
- ☐ Sex Partners of Person at Risk
- ☐ Exposure Incident
- ☐ Other (specify) _____
- ☐ IV Drug User
- ☐ Hemophiliac
- ☐ Perinatal
- ☐ Tattoo
- ☐ Unknown

ATTACHMENT B

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
MEDICAL SERVICES REQUEST

PATIENT NAME (PLEASE PRINT)	INSTITUTION	DATE RECEIVED BY MEDICAL
	DOC NUMBER / DOB / DATE	
HOUSING UNIT	WORK/SCHOOL SCHEDULE	
I WISH TO BE SEEN BY (CHECK ONE) ☐ MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ OTHER	FOR	
REQUESTING OVER THE COUNTER (OTC) MEDICATION ONLY ☐ WHAT MEDICATION?	WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?	
WHAT EXISTING MEDICAL CONDITIONS HAVE BEEN DIAGNOSED?		
PATIENT SIGNATURE AND AUTHORIZATION TO TREAT	INITIAL FOR RECEIPT OF OTC INSTRUCTIONS / DATE / TIME	

DO NOT WRITE BELOW THIS LINE - FOR MEDICAL USE ONLY

TRIAGE NURSE — DATE

☐ Routine ☐ Urgent ☐ Emergent
☐ Mental Health ☐ Visit Scheduled ☐ Doctor Review, No Visit/Last Seen _____
☐ To DON ☐ Medication Rm
☐ To Dental ☐ Doctor Sick Call
☐ To Optometry ☐ Nurse Sick Call
☐ To Lab/X-Ray ☐ To Administrator

SCHEDULING

☐ Appointment Scheduled _____ (Initials)
☐ Protocol Code to be Scheduled: _____
☐ Complaint Code to be Scheduled (If No Protocol Available): _____ See Current Listing (F19)

NURSING VISIT

VITALS _____ P _____ R _____ B/P _____ Wt. _____

ORTHOSTATIC VITALS	STANDING	SITTING	LYING
	BP ____ P ____	BP ____ P ____	BP ____ P ____

☐ Documentation in computerized medical record
☐ Protocol completed
☐ Follow up in _____ days per MSR if no improvement

NURSE SIGNATURE — DATE — TIME

PHYSICIAN VISIT

☐ Documentation in computerized medical record
☐ Medically Unnecessary or Cosmetic Procedure
☐ Follow up in _____ days per MSR if no improvement
☐ Referral or Non-Formulary Medication requested via computer

PHYSICIAN SIGNATURE — DATE — TIME

MEDICAL ACTION TAKEN	DATE/INITIALS	MEDICAL ACTION TAKEN	DATE/INITIALS
☐ Follow Up Physician Visit Scheduled		☐ Chronic Care Clinic Visit Scheduled	
☐ Follow Up Nursing Visit Scheduled		☐ Laboratory Test(s) Ordered / Scheduled	
☐ Follow Up Nurse Practitioner Visit Scheduled		☐ X-Ray(s) Ordered / Scheduled	
☐ Pending Referral or Non-Formulary		☐ Medications ordered	
☐ Follow up with Physician when above is completed.			

OFFENDER NAME	DOC NUMBER	INSTITUTION	HOUSING UNIT

MEDICAL ACTION TAKEN	DATE/INITIALS	MEDICAL ACTION TAKEN	DATE/INITIALS
☐ Follow Up Physician Visit Scheduled		☐ Chronic Care Clinic Visit Scheduled	
☐ Follow Up Nursing Visit Scheduled		☐ Laboratory Test(s) Ordered / Scheduled	
☐ Follow Up Nurse Practitioner Visit Scheduled		☐ X-Ray(s) Ordered / Scheduled	
☐ Pending Referral or Non-Formulary		☐ Medications Ordered	
☐ Other			

REVIEWED BY — DATE — TIME

DEPARTMENT OF CORRECTIONS

MEDICAL INFORMATION RELEASE AUTHORIZATION

ATTACHMENT C

OFFENDER NAME	NUMBER

I AM AWARE THAT I AM INFECTED WITH HIV (AIDS)

☐ By this document, I authorize the Department of Corrections to disclose the results of my HIV testing to public employees of agencies, departments or other political subdivisions who need to know the results of this HIV test to perform their public duties.

☐ By this document, I authorize the Department of Corrections to make a good faith determination of who needs to know the results of my HIV testing to perform their public duties.

☐ By this document, I authorize the Department of Corrections to determine in good faith whether the person or persons referred to have a proper interest in this information and to determine whether my best interest or welfare makes this action desirable or helpful.

The consequences of signing this authorization document and the consequences of refusing to sign this authorization document have been explained to me.

OFFENDER SIGNATURE	DATE
WITNESS SIGNATURE	DATE

ATTACHMENT D

DEPARTMENT OF CORRECTIONS
NEGATIVE HIV TEST RESULTS

OFFENDER NAME	DOC NUMBER	INSTITUTION

You were recently tested for the presence of the HIV antibody in your blood. Your test did not find HIV antibody in your blood. This does not mean that you cannot test positive for the HIV at some time in the future. You should direct any questions to your institution's medical unit staff. You are advised not to disclose your results to anyone.

My signature acknowledges that I have received HIV post-test counseling and that I have been officially notified and I understand the above results.

OFFENDER SIGNATURE	DATE	MEDICAL STAFF SIGNATURE	DATE

MO 931-3761 (8-99)

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
NEGATIVE HIV TEST RESULTS

OFFENDER NAME	DOC NUMBER	INSTITUTION

You were recently tested for the presence of the HIV antibody in your blood. Your test did not find HIV antibody in your blood. This does not mean that you cannot test positive for the HIV at some time in the future. You should direct any questions to your institution's medical unit staff. You are advised not to disclose your results to anyone.

My signature acknowledges that I have received HIV post-test counseling and that I have been officially notified and I understand the above results.

ER SIGNATURE	DATE	MEDICAL STAFF SIGNATURE	DATE

931-3761 (8-99)

DEPARTMENT OF CORRECTIONS

ATTACHMENT E

INCONCLUSIVE HIV TEST RESULTS

OFFENDER NAME	DOC NUMBER	INSTITUTION

You were recently tested for the presence of the HIV antibody in your blood. Your test was INCONCLUSIVE. This means that the initial HIV test (ELISA) was positive and the confirmatory HIV test (WESTERN BLOT) is negative. Because of these results, you will be retested in 30 days.

The Health Services Administrator or designee will advise you concerning future care related to HIV. You are advised not to disclose your test results to anyone except as required by law. Law requires notification of your health care provider(s) and sexual partners.

My signature acknowledges that I have received HIV post-test counseling and that I have been officially notified and I understand the above results.

OFFENDER SIGNATURE	DATE	MEDICAL STAFF SIGNATURE	DATE

MO 931-4212 (8-99)

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
INCONCLUSIVE HIV TEST RESULTS

OFFENDER NAME	DOC NUMBER	INSTITUTION

You were recently tested for the presence of the HIV antibody in your blood. Your test was INCONCLUSIVE. This means that the initial HIV test (ELISA) was positive and the confirmatory HIV test (WESTERN BLOT) is negative. Because of these results, you will be retested in 30 days.

The Health Services Administrator or designee will advise you concerning future care related to HIV. You are advised not to disclose your test results to anyone except as required by law. Law requires notification of your health care provider(s) and sexual partners.

My signature acknowledges that I have received HIV post-test counseling and that I have been officially notified and I understand the above results.

OFFENDER SIGNATURE	DATE	MEDICAL STAFF SIGNATURE	DATE

MO 931-4212 (8-99)

ATTACHMENT F

DEPARTMENT OF CORRECTIONS
EQUIVOCAL HIV TEST RESULTS

OFFENDER NAME	DOC NUMBER	INSTITUTION

You were recently tested for the presence of the HIV antibody in your blood. Your test was EQUIVOCAL. This means that the confirmation HIV test was neither positive or negative. It also means that there is a higher possibility that you are infected with HIV.

Because of these results, you will be retested in 30 days. Follow-up testing will depend on the retesting results. The Health Services Administrator or designee will advise you concerning any future care related to HIV. You are advised not to disclose your test results to anyone except as required by law. Since it is not possible to exclude you as being infected with HIV, law requires you to notify health care provider(s) and sexual partners of your HIV status.

My signature acknowledges that I have received HIV post-test counseling and that I have been officially notified and I understand the above results.

OFFENDER SIGNATURE	DATE	MEDICAL STAFF SIGNATURE	DATE

MO 931-4213 (8-99)

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
EQUIVOCAL HIV TEST RESULTS

OFFENDER NAME	DOC NUMBER	INSTITUTION

You were recently tested for the presence of the HIV antibody in your blood. Your test was EQUIVOCAL. This means that the confirmation HIV test was neither positive or negative. It also means that there is a higher possibility that you are infected with HIV.

Because of these results, you will be retested in 30 days. Follow-up testing will depend on the retesting results. The Health Services Administrator or designee will advise you concerning any future care related to HIV. You are advised not to disclose your test results to anyone except as required by law. Since it is not possible to exclude you as being infected with HIV, law requires you to notify health care provider(s) and sexual partners of your HIV status.

My signature acknowledges that I have received HIV post-test counseling and that I have been officially notified and I understand the above results.

ER SIGNATURE	DATE	MEDICAL STAFF SIGNATURE	DATE

931-4213 (8-99)

INTERVENTION/PREVENTION SERVICES

26. [Y] [N] Patient (or Parent/Guardian) Informed of HIV Infection Status
[Y] [N] Physician Has Performed Spousal Notification
[Y] [N] Physician Requests Partner Notification Assistance
[Y] [N] Physician Requests Support/Referral Information Services
[Y] [N] Patient is Receiving Treatment for HIV/AIDS
If Yes, ☐ Antiretroviral ☐ OI Prophylaxis

27. PATIENT'S MEDICAL TREATMENT PRIMARILY REIMBURSED BY:
☐ Private Insurance, HMO ☐ Medicare
☐ Private Insurance, Non HMO ☐ Self Pay
☐ Medicaid Managed Care ☐ No Coverage
☐ Medicaid Fee-for-Service ☐ Other: _____

28. PHYSICIAN NAME, ADDRESS, TELEPHONE:

29. PERSON COMPLETING HIV REPORT:

30. DATE:

31. COMMENTS:

TO REFER AN HIV-INFECTED CLIENT

FOR: *HIV/AIDS Care Case Management Services*
KANSAS CITY: 816/513-6229; ST. LOUIS: 314/612-5188
Or the Missouri Department of Health and Senior Services (MDHSS)
Section of STD/HIV
Jefferson City, MO - PH: 573/751-6439

FOR: *Public Health Counseling and Intervention Services (Partner Notification OR Level II Client*)*
Kansas City: 816/513-6152; St. Louis: 314/612-5200
Your Local County or District Health Office, or the MDHSS
Office of Surveillance, Jefferson City, MO - PH: 573/751-6148

TO OBTAIN ADDITIONAL INFORMATION:
- HIV CLINICAL CONSULTATION SERVICE: 1-800-933-3413
- OCCUPATIONAL EXPOSURE PROPHYLAXIS HOTLINE: 1-888-448-4911
- HIV/AIDS TREATMENT INFO. SERVICE: 1-800-HIV-0440
- NATIONAL AIDS HOTLINE: 1-800-342-AIDS
- MO HIV/STD HOTLINE: 1-800-533-AIDS
- KC HIV/AIDS HOTLINE: 816/ 513-6000

(*An HIV-infected person who knowingly continues to expose others to HIV)

Health Department Use Only: Type of Report: VY SD
Initial Source: _____ Report Source: _____

To Report Confirmed HIV/AIDS Infection (within 3 Days of Diagnosis) or Obtain Additional Report Forms, Contact the Missouri Department of Health and Senior Services or Appropriate City Health Department (Addresses Below)

SUBMIT REPORT TO:

Missouri Department of Health & Senior Serv.-OOS
930 Wildwood, P.O. Box 570
Jefferson City, MO 65102-0570
Tel: (573) 751-6463

Kansas City Health Department
Suite 2100, Surveillance Unit
2400 Troost Ave., Kansas City, MO 64108
Tel: (816) 513-6152

St. Louis Dept. of Health and Hospitals
Surveillance Unit / Room 436
634 No. Grand Blvd., St. Louis, MO 63103
Tel: (314) 612-5188

MO 580-1641 (4-02)

SHP-22

PHYSICIAN'S CONFIDENTIAL REPORT OF HIV INFECTION

PATIENT INFORMATION

1. PATIENT ID NUMBER *(FROM LAB SLIP)*

2. PATIENT NAME *(LAST, FIRST, MI)*

3. ADDRESS *(STREET, APT. #, P.O. BOX NO.)*

CITY, STATE, ZIP CODE

COUNTY

4. TELEPHONE ( )

5. SS #

6. DCN #

7. DATE OF BIRTH

8. AGE

9. MARITAL STATUS [S] [M] [D] [W]

10. SEX [M] [F]

11. RACE
☐ White ☐ Asian/Pacific Is.
☐ Black ☐ Am. Indian/AK Native
☐ Other: _____

12. Hispanic Ethnicity ☐ Yes ☐ No

13. VITAL STATUS ☐ Living ☐ Deceased – Date of Death: ___ / ___ / ___

14. COUNTRY OF BIRTH ☐ U.S. ☐ Other: _____ ☐ Unknown

17. FOR ADULT FEMALES Hepatitis B: HBsAg ☐ Pos ☐ Neg
[Y] [N] Patient is Currently Pregnant EDC: ___ / ___ / ___
If Yes, Week of Pregnancy Antiretroviral Therapy Began: _____
☐ ZDV (AZT) ☐ Other: _____

PATIENT HISTORY

15. AFTER 1977, THIS PATIENT HAD: *(CHECK ALL THAT APPLY)*

Y	N	
☐	☐	Sex With Male
☐	☐	Sex With Female
☐	☐	Injected Non-Prescription Drugs
☐	☐	Received Clotting Factor ☐ VIII ☐ IX ☐ Other: _____
☐	☐	Blood Transfusion: First ___ / ___ Last ___ / ___
☐	☐	Worked In Health Care Setting: Occupation: _____
☐	☐	Recipient Of Tissue/Organs/Artificial Insemination Date: ___ / ___

HETEROSEXUAL RELATIONS WITH:
☐ ☐ Injection Drug User
☐ ☐ Bisexual Male
☐ ☐ Person With Hemophilia/Coagulation Disorder
☐ ☐ Transfusion/Transplant Recipient With Documented HIV Infection
☐ ☐ Person With AIDS/HIV Infection Whose Risk Is Not Known

16. FOR PEDIATRIC/PERINATAL CASES
[Y] [N] IF < 13 YEARS OF AGE, MOTHER WITH HIV/AIDS?
If Yes, Mother's Name: _____ Mother's DOB: ___ / ___ / ___
If Newborn, Date Anti-Retroviral Therapy for HIV Prevention Began: ___ / ___ / ___

Number of Live-Born Infants Delivered in the Last 18 Months: _____
Provide Birth Information for Most Recent Birth(s):
DOB: ___/___/___ Birth Hospital: _____ Breastfed [Y] [N]
DOB: ___/___/___ Birth Hospital: _____ Breastfed [Y] [N]

MO 580-1641 (4-02)

(CONTINUED)

SHP-22

LABORATORY DATA

18. CURRENT HIV TEST(s)

HIV Antibody Tests:	Pos	Neg	Incon-clusive	Not Done	TEST DATE MM/DD/YY
HIV-1 EIA	☐	☐	☐	☐	___/___/___
HIV-1 Western Blot/IFA	☐	☐	☐	☐	___/___/___
HIV-1/HIV-2 Combination EIA	☐	☐	☐	☐	___/___/___
Other: _____	☐	☐	☐	☐	___/___/___

HIV Antibody Test Specimen Was:
☐ Serum ☐ Oral Fluid ☐ Urine ☐ Other: _____

HIV Detection Tests:	Pos	Neg	Incon-clusive	Not Done	TEST DATE MM/DD/YY
PCR, DNA or RNA Probe	☐	☐	☐	☐	___/___/___
Culture	☐	☐	☐	☐	___/___/___
Antigen Test	☐	☐	☐	☐	___/___/___
Other: _____	☐	☐	☐	☐	___/___/___

/IRAL LOAD TESTING: (Record most recent testing) TEST DATE MM/DD/YY
☐ Detectable ☐ Non-Detectable
Test Type* ☐☐ Copies/ml ☐, ☐☐☐, ☐☐☐ ___/___/___
Type 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA (Chiron) 18. Other 19. Unspecified

19. TESTING LABORATORY NAME(S), ADDRESS(ES), TELEPHONE NUMBER(S):

20. IF HIV TESTS ARE NOT DOCUMENTED, IS HIV DIAGNOSED BY A PHYSICIAN?
[Y] [N] If Yes, Diagnosis Date: _____/_____
Provider: _____ City/State: _____

21. [Y] [N] Patient is Past or Present HIV Vaccine Trial Participant

22. PREVIOUS HIV TEST? [Y] [N] If Yes, Most Recent Result: [P] [N] [In]
Type of Test: ☐ Antibody ☐ Antigen ☐ PCR ☐ Culture
☐ Qualitative PCR ☐ Quantitative PCR (VL)
☐ Other (specify) _____ Test Date: ____/____/____
Provider: _____
City/State: _____

If Previously Tested, Reason for Retest:
☐ Case Management Eligibility ☐ Medicaid/Medicare Eligibility
☐ High Risk Negative ☐ Client Request
☐ Confirm Diagnosis ☐ Other: _____

23. CD4+ LYMPHOCYTE COUNT: TEST DATE MO/YR

Most Recent CD4+ Count	[ ],[ ][ ][ ] cells/μL	____/____
CD4+ Percent	[ ][ ] %	____/____
First CD4+below 200μL or 14% (If Known)	[ ],[ ][ ][ ] cells/μL	____/____
	[ ][ ] %	____/____

MO 580-1641 (4-02) SHP-22

CLINICAL STATUS

24. [Y] [N] PATIENT MEDICALLY EVALUATED? If Yes, Check All That Apply
☐ Asymptomatic
☐ Symptomatic, No History of AIDS-Defining Illness
☐ CD4+ is now or has been <200/14%
☐ Symptomatic, AIDS-Defining Illness Diagnosed

	Def.	Pres.	Mo/Yr
• Candidiasis, bronchi, trachea, lungs	☐	☐	____/____
• Candidiasis, esophageal	☐	☐	____/____
• Carcinoma, invasive cervical	☐	☐	____/____
• Coccidioidomycosis, disseminated or extrapulmonary	☐	☐	____/____
• Cryptococcosis, extrapulmonary	☐	☐	____/____
• Cryptosporidiosis, chronic intestinal	☐	☐	____/____
• Cytomegalovirus disease (other than liver, spleen, or nodes)	☐	☐	____/____
• Cytomegalovirus retinitis (vision loss)	☐	☐	____/____
• HIV encephalopathy	☐	☐	____/____
• Herpes simplex: chronic ulcer(s); or bronchitis, pneumonitis, esophagitis	☐	☐	____/____
Histoplasmosis, dissem. or extrapulm.	☐	☐	____/____
• Isosporiasis, chronic intestinal (>1 mo)	☐	☐	____/____
• Kaposi's sarcoma	☐	☐	____/____
• Lymphoma, Burkitt's (or equivalent)	☐	☐	____/____
• Lymphoma, immunoblastic (or equiv.)	☐	☐	____/____
• Lymphoma, primary in brain	☐	☐	____/____
• *M. avium* complex or *M. kansasii*, disseminated or extrapulmonary	☐	☐	____/____
• *M. tuberculosis*, pulmonary	☐	☐	____/____
• *M. tuberculosis*, dissem. or extrapulm.	☐	☐	____/____
• *Mycobacterium*, of other or unidentified species, dissem. or extrapulm.	☐	☐	____/____
• *Pneumocystis carinii* pneumonia	☐	☐	____/____
• Pneumonia, recurrent in 12 mo period	☐	☐	____/____
• Progressive multifocal leukoencephalopathy	☐	☐	____/____
• *Salmonella* septicemia, recurrent	☐	☐	____/____
• Toxoplasmosis of brain	☐	☐	____/____
• Wasting syndrome due to HIV	☐	☐	____/____

Pediatric: *(Additional Indicator Diseases)*

• Bacterial infections, multiple or recurrent, (incl. *Salmonella* septicemia)	☐	☐ ____/____
• Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	☐	☐ ____/____

25. If AIDS, Facility of Diagnosis: _____
City/State: _____
☐ Public ☐ Private ☐ Federal

TYPE OF FACILITY WHERE AIDS WAS DIAGNOSED: *(Check One)*
☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Public Clinic
☐ Physician's Office ☐ Other: _____

Def. = definitive diagnosis Pres. = presumptive diagnosis Mo/Yr = date of initial diagnosis

MO 580-1641 (4-02) (CONTINUED ON BACK) SHP-22

ATTACHMENT H

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

HIV/AIDS SUMMARY TREATMENT RECORD

INMATE NAME		DOC NUMBER		LOCATION		
DATE OF VISIT						
WEIGHT						
FLU VACCINE						
PNEUMOVAX						
PPD						
PCP PROPHYLAXIS						
MAC PROPHYLAXIS						
EYE EXAM						
HEPATITIS B						
PE (X if done)						
VIRAL LOAD						
CD4						
CBC						
G6PD						
MEDICATIONS						
NURSE NAME						
PHYSICIAN NAME						

FOR DOCUMENTATION OF TREATMENTS DONE AT EACH VISIT

MO 931-4033 (3-97)

ATTACHMENT I

HIV INFECTION STATUS NOTIFICATION

TO	INSTITUTIONAL PAROLE OFFICE	FROM	INFECTION CONTROL NURSE
SUBJECT	HIV INFECTION STATUS	OFFENDER NAME	DOC NUMBER

The above named offender has recently been tested for HIV and her/his test has been tested "positive". This is indicative that the offender has been exposed to the Human Immunodificiency Virus and at this time is considered infected. She/he will require ongoing follow-up.

She/he has received diagnostic testing and possible treatment has been implemented. She/he has been counseled on what HIV is and the State Law regarding risky activity and notification of contacts. She/he has been followed in our Chronic Care Clinic.

A Discharge Plan has been implemented with the Department of Health prior to the release of this offender. ☐

Offender is presently on HIV medications ☐

Offender is not presently on HIV medications ☐

Thank you for your assistance in ensuring continuity of care for this offender upon her/his release.

MEDICAL STAFF SIGNATURE	DATE

MO 931-4180 (3-99) DISTRIBUTION: ORIGINAL - MEDICAL FILE CANARY - INSTITUTIONAL PAROLE OFFICER

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

HIV INFECTION STATUS NOTIFICATION

INSTITUTION

TO	INSTITUTIONAL PAROLE OFFICE	FROM	INFECTION CONTROL NURSE
SUBJECT	HIV INFECTION STATUS	OFFENDER NAME	DOC NUMBER

The above named offender has recently been tested for HIV and her/his test has been tested "positive". This is indicative that the offender has been exposed to the Human Immunodificiency Virus and at this time is considered infected. She/he will require ongoing follow-up.

She/he has received diagnostic testing and possible treatment has been implemented. She/he has been counseled on what HIV is and the State Law regarding risky activity and notification of contacts. She/he has been followed in our Chronic Care Clinic.

A Discharge Plan has been implemented with the Department of Health prior to the release of this offender. ☐

Offender is presently on HIV medications ☐

Offender is not presently on HIV medications ☐

Thank you for your assistance in ensuring continuity of care for this offender upon her/his release.

STAFF SIGNATURE	DATE

) 931-4180 (3-99) DISTRIBUTION: ORIGINAL - MEDICAL FILE CANARY - INSTITUTIONAL PAROLE OFFICER

DEPARTMENT OF CORRECTIONS
POSITIVE HIV TEST RESULTS

OFFENDER NAME	DOC NUMBER	INSTITUTION

You were recently tested for the presence of the HIV antibody in your blood. Your test is reactive, which means you have the HIV antibody and are a carrier of the virus.

The Health Services Administrator or designee will advise you concerning future care related to HIV. You are advised not to disclose your test results to anyone except as required by law. Law requires notification of your health care provider(s) and sexual partners.

My signature acknowledges that I have received HIV post-test counseling and that I have been officially notified and I understand the above results.

OFFENDER SIGNATURE	DATE	MEDICAL STAFF SIGNATURE	DATE

MO 931-4211 (8-99)

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
POSITIVE HIV TEST RESULTS

OFFENDER NAME	DOC NUMBER	INSTITUTION

You were recently tested for the presence of the HIV antibody in your blood. Your test is reactive, which means you have the HIV antibody and are a carrier of the virus.

The Health Services Administrator or designee will advise you concerning future care related to HIV. You are advised not to disclose your test results to anyone except as required by law. Law requires notification of your health care provider(s) and sexual partners.

My signature acknowledges that I have received HIV post-test counseling and that I have been officially notified and I understand the above results.

ER SIGNATURE	DATE	MEDICAL STAFF SIGNATURE	DATE

931-4211 (8-99)

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010

Richard C. Dunn
Director

Bob Holden
Governor

CORRECTIONAL MEDICAL SERVICES REFERRAL TO POSITIVE START TRANSITIONAL CASE MANAGEMENT

Date of Referral: _____ /_____ / _____

Referral Correctional Center: _____

Referral Contact: _____ **Phone Number:** _____

OFFENDER REFERRED

Name: _____ Race: _____

Date of Birth: _____ Social Security Number: _____

Department of Correction Number: _____

Date of HIV Diagnosis: _____ CD4 Count: _____ Date: _____

Viral Load: _____ Date: _____

DATE OF DISCHARGE: _____ Discharge Phone: _____

Discharge Address: _____

Previously in Medical Care: ____Y ____N Physician: _____

Current Medications: _____ _____

_____ _____

_____ _____

Co-morbidity: _____

Special Needs: _____

COMMENTS: _____

PLEASE FAX THE REFERRAL TO: ***Roberta Renicker RN BSN MSA 573-751-6447***

Department of Health and Senior Services
Section of STD/HIV
930 Wildwood, PO Box 570
Jefferson City, MO 65102-0570

For DHSS use only:

DCN: _____

Previously in Positive Start database: ____Yes ____ No

Previously in Case Management: ____Yes ____No

Previous TCM: _____

ATTACHMENT I.

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT

– Patient identifier information is not transmitted to CDC! –

DEPARTMENT OF HEALTH
'MAN SERVICES
s for Disease Control
revention

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≥13 years of age at time of diagnosis)

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved OMB No. 0920-0009

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

II. HEALTH DEPARTMENT USE ONLY

SOUNDEX CODE:

REPORT STATUS: [1] New Report [2] Update

REPORTING HEALTH DEPARTMENT: State: City/County:

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT (check one): [1] HIV Infection (not AIDS) [2] AIDS

AGE AT DIAGNOSIS: _____ Years _____ Years

DATE OF BIRTH: Mo. Day Yr.

CURRENT STATUS: Alive [1] Dead [2] Unk. [9]

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH: _____

SEX: [1] Male [2] Female

RACE/ETHNICITY: [1] White (not Hispanic) [2] Black (not Hispanic) [3] Hispanic [4] Asian/Pacific Islander [5] American Indian/ Alaska Native [9] Not Specified

COUNTRY OF BIRTH: [1] U.S. [7] U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____ [8] Other (specify): _____ [9] Unknown

RESIDENCE AT DIAGNOSIS:

City: _____ County: _____ State/ Country: _____ Zip Code: _____

IV. FACILITY OF DIAGNOSIS

Facility Name

City

late/Country

'LITY SETTING (check one)

Public [2] Private [3] Federal [9] Unk.

FACILITY TYPE (check one)

[01] Physician, HMO [31] Hospital, Inpatient

[88] Other (specify): _____

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

V. PATIENT HISTORY

AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
• Sex with male	[1]	[0]	[9]
• Sex with female	[1]	[0]	[9]
• Injected nonprescription drugs	[1]	[0]	[9]
• Received clotting factor for hemophilia/coagulation disorder	[1]	[0]	[9]

Specify disorder: [1] Factor VIII (Hemophilia A) [2] Factor IX (Hemophilia B) [8] Other (specify): _____

• *HETEROSEXUAL* relations with any of the following:			
• Intravenous/injection drug user	[1]	[0]	[9]
• Bisexual male	[1]	[0]	[9]
• Person with hemophilia/coagulation disorder	[1]	[0]	[9]
• Transfusion recipient with documented HIV infection	[1]	[0]	[9]
• Transplant recipient with documented HIV infection	[1]	[0]	[9]
• Person with AIDS or documented HIV infection, risk not specified	[1]	[0]	[9]
• Received transfusion of blood/blood components (other than clotting factor)	[1]	[0]	[9]

First Mo. Yr. Last Mo. Yr.

• Received transplant of tissue/organs or artificial insemination	[1]	[0]	[9]
• Worked in a health-care or clinical laboratory setting	[1]	[0]	[9]

(specify occupation): _____

VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)

	Pos	Neg	Ind	Not Done	TEST DATE Mo.	Yr.
• HIV–1 EIA	[1]	[0]	–	[9]		
• HIV–1/HIV–2 combination EIA	[1]	[0]	–	[9]		
• HIV–1 Western blot/IFA	[1]	[0]	[8]	[9]		
• Other HIV antibody test (specify): _____	[1]	[0]	[8]	[9]		

2. POSITIVE HIV DETECTION TEST: (Record earliest test) Mo. Yr.

[ ] culture [ ] antigen [ ] PCR, DNA or RNA probe

Other (specify): _____

3. DETECTABLE VIRAL LOAD TEST: (Record most recent test)

Test type* COPIES/ML Mo. Yr.

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

- Date of last documented negative HIV test (specify type): _____ Mo. Yr.

	Yes	No	Unk.
• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?	[1]	[0]	[9]

If yes, provide date of documentation by physician ..... Mo. Yr.

4. IMMUNOLOGIC LAB TESTS:

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

		Mo.	Yr.
• CD4 Count	[ ],[ ][ ][ ] cells/µL		
• CD4 Percent	[ ][ ] %		

First <200 µL or <14%

		Mo.	Yr.
• CD4 Count	[ ],[ ][ ][ ] cells/µL		
• CD4 Percent	[ ][ ] %		

Physician's Name: (Last, First, M.I.) _____ Phone No.: ( ) _____ Medical Record No. _____

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Patient identifier information is not transmitted to CDC! –

VIII. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes [1] No [0]

ENTER DATE PATIENT WAS DIAGNOSED AS: Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo. Yr. Symptomatic (not AIDS): Mo. Yr.

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo. Yr.
Candidiasis, bronchi, trachea, or lungs	[1]	NA	
Candidiasis, esophageal	[1]	[2]	
Carcinoma, invasive cervical	[1]	NA	
Coccidioidomycosis, disseminated or extrapulmonary	[1]	NA	
Cryptococcosis, extrapulmonary	[1]	NA	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	[1]	NA	
Cytomegalovirus disease (other than in liver, spleen, or nodes)	[1]	NA	
Cytomegalovirus retinitis (with loss of vision)	[1]	[2]	
HIV encephalopathy	[1]	NA	
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	[1]	NA	
Histoplasmosis, disseminated or extrapulmonary	[1]	NA	
Isosporiasis, chronic intestinal (>1 mo. duration)	[1]	NA	
posi's sarcoma	[1]	[2]	

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo. Yr.
Lymphoma, Burkitt's (or equivalent term)	[1]	NA	
Lymphoma, immunoblastic (or equivalent term)	[1]	NA	
Lymphoma, primary in brain	[1]	NA	
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	[1]	[2]	
M. tuberculosis, pulmonary*	[1]	[2]	
M. tuberculosis, disseminated or extrapulmonary*	[1]	[2]	
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	[1]	[2]	
Pneumocystis carinii pneumonia	[1]	[2]	
Pneumonia, recurrent, in 12 mo. period	[1]	[2]	
Progressive multifocal leukoencephalopathy	[1]	NA	
Salmonella septicemia, recurrent	[1]	NA	
Toxoplasmosis of brain	[1]	[2]	
Wasting syndrome due to HIV	[1]	NA	

Def. = definitive diagnosis Pres. = presumptive diagnosis

* RVCT CASE NO.:

• If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? [1] Yes [0] No [9] Unknown

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? [1] Yes [0] No [9] Unk.

This patient's partners will be notified about their HIV exposure and counseled by:
[1] Health department [2] Physician/provider [3] Patient [9] Unknown

This patient is receiving or has been referred for:

	Yes	No	NA	Unk.
• HIV related medical services	[1]	[0]	–	[9]
• Substance abuse treatment services	[1]	[0]	[8]	[9]

This patient received or is receiving:

	Yes	No	Unk.
• Anti-retroviral therapy	[1]	[0]	[9]
• PCP prophylaxis	[1]	[0]	[9]

This patient has been enrolled at:

Clinical Trial	Clinic
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is primarily reimbursed by:
[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other Public Funding
[7] Clinical trial/ government program [9] Unknown

FOR WOMEN:
- This patient is receiving or has been referred for gynecological or obstetrical services: [1] Yes [0] No [9] Unknown
- Is this patient currently pregnant? [1] Yes [0] No [9] Unknown
- Has this patient delivered live-born infants? [1] Yes (if delivered after 1977, provide birth information below for the most recent birth) [0] No [9] Unknown

CHILD'S DATE OF BIRTH: Mo. Day Yr.

Hospital of Birth: _____ City: _____ State: _____

Child's Soundex:

Child's State Patient No.:

COMMENTS: _____

oos
confidential

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

MO 580-1759 (9-01)

BUSINESS REPLY MAIL

FIRST CLASS MAIL PERMIT NO. 160 JEFFERSON CITY, MO

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
P O BOX 570
JEFFERSON CITY MO 65102-9813

****

MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-14.5 Personal Protective Equipment Effective Date: January 23, 2006

Ralf J. Salke
Vice President of Operations

Elizabeth Conley, D.O.
Regional Medical Director

Terry Moore, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure has been developed to ensure personal protective equipment required for respiratory isolation or universal blood and body fluid precautions is readily available for health care staff coming in contact with infectious offenders in infirmaries.

A. **AUTHORITY:** 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure (SOP) specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Personal Protective Equipment:** Consist of goggles, mask, gloves, CPR mask with a one way valve and an impervious gown.

B. **Emergency Response Bags:** A tote or canvas bag that at a minimum contains personal protective equipment.

III. **PROCEDURES:**

A. Personal protective equipment should be available for use by health care staff in areas where exposure to blood or body fluids may be reasonably expected to occur.

1. Personal protective equipment will be provided and maintained for the purpose of this procedure by the health services administrator.

2. The health service administrator/designee will ensure equipment is available for staff through monthly unit checklist monitoring and safety inspections.

B. Emergency response bags will contain personal protective equipment.

C. The health care staff may request any other items that may be required for personal protection for universal blood and body fluid precautions through the health services administrator.

D. A bag containing disposable gloves, fluid impervious gown, goggles, and a mask, should be readily available and accessible in all offender health treatment areas .

E. Used supplies should be disposed of in appropriate containers and bag contents replaced by the health service administrator/designee by the end of the shift for which the supplies were used.

F. Health care staff shall communicate the use of personal protective equipment to the health services administrator/designee and superintendent/designee whenever special precautions are required for patient transportation utilizing Medical Transportation Requirements form (Attachment A).

IV. ATTACHMENTS

A. 931-4171 Medical Transportation Requirements

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-B-01 Infection Control Program – *essential,* P-B-02 Environmental Health and Safety – *essential.*

B. CMS Infection Control Manual

VI. HISTORY: This policy was originally covered by IS11-14.5 Personal Protective Equipment Procedure, located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: January 23, 2006

ATTACHMENT A

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

MEDICAL TRANSPORTATION REQUIREMENTS

OFFENDER NAME	DOC NUMBER

INSTITUTION

CHECK APPLICABLE AREA

1. PRIVATE TRANSPORTATION	2. ARE MASKS INDICATED	3. TYPE
☐ YES ☐ NO	☐ YES ☐ NO	☐ N-95 ☐ SURGICAL ☐ HEPA

*NOTE: AT LEAST ONE WINDOW MUST BE OPENED A MINIMUM OF 1/2 INCH TO ALLOW FOR PROPER VENTILATION.

4. ARE GOWNS INDICATED

☐ YES IF SOILING IS LIKELY ☐ YES FOR ALL RIDING IN VEHICLE OR ENTERING ROOM ☐ NO

5. ARE GLOVES INDICATED

☐ YES FOR TOUCHING CONTAMINATED MATERIALS ☐ YES FOR ALL RIDING IN VEHICLE OR ENTERING ROOM ☐ NO

6. **UNIVERSAL PRECAUTIONS** SHOULD BE FOLLOWED. SPECIAL PRECAUTIONS ARE ALWAYS INDICATED FOR HANDLING **BLOOD.** (REFER TO D5-5.2)

7. THE FOLLOWING CONTAMINATED MATERIALS OR *BODY FLUIDS ARE DOUBLE BAGGED AND LABELED PRIOR TO BEING PLACED IN THE TRUNK OF THE VEHICLE. THESE MATERIALS ARE THEN TURNED OVER TO INSTITUTIONAL MEDICAL STAFF FOR DISPOSAL.

***BODY FLUIDS** INCLUDE BLOOD, SEMEN, DRAINAGE FROM SCRAPES AND CUTS, FECES, URINE, VOMITUS, RESPIRATORY SECRETIONS (I.E., NASAL DISCHARGE) AND SALIVA.

8. ADDITIONAL PRECAUTIONS OR INSTRUCTIONS:

MEDICAL STAFF PRINTED NAME		
ICAL STAFF SIGNATURE	DATE	TIME
TRANSPORTING OFFICER PRINTED NAME	TRANSPORTING OFFICER SIGNATURE	
TRANSPORTING OFFICER PRINTED NAME	TRANSPORTING OFFICER SIGNATURE	

MO 931-4171 (6-99) DISTRIBUTION: **WHITE** - EMPLOYEE HEALTH COORDINATOR **CANARY** - FIRE/SAFETY SPECIALIST (SENDING INSTITUTION)
PINK - CENTRAL TRANSPORTATION UNIT FILE

****

MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-14.4 HIV Infected Offenders Effective Date: October 22, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. **Purpose:** This procedure has been developed to establish guidelines to comply with the CDC standards of care for assisting HIV infected offenders.

A. **AUTHORITY:** 191.659, 217.175, 217.320, RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institutions or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **HIV Positive:** Infection with the human immunodeficiency virus.

B. **AIDS:** Acquired Immune Deficiency Syndrome (AIDS): A medical condition caused by the Human Immunodeficiency Virus (HIV) which results in the destruction of the body's natural defenses against disease and is characterized by certain medical conditions as defined by the Center for Disease Control and Prevention (CDC) and American Medical Association (AMA).

C. **High Risk Behavior:** An incident of behavior, which suggests the possibility of exposure to infection to include but not, limited to:

a. sexual contact that involves the exchanges of body fluids to which standard precautions apply;
b. injection drug use;
c. possession of needles or syringes;

d. tattooing and piercing of a body part; and,
e. involvement in an incident where one's blood is exposed to another person. The person exposed may be staff or offender.

III. PROCEDURES:

A. Written consent should be obtained from the offender prior to obtaining a blood sample for HIV testing, unless otherwise provided by state statute without the right of refusal.

B. Offenders tested for HIV should have pre- and post-test counseling by nursing staff.

C. Usual laboratory (test results that physicians interpret) determinations should be utilized to confirm the HIV positive status of a tested offender to reduce the incidence of false positive reports.

D. Offenders who are HIV positive should not be segregated from general population offenders unless medically indicated or if they engage in high-risk behaviors.

E. In accordance with the community standards of care, confidentiality regarding the HIV/AIDS status of an offender should be maintained within the control of the health services unit.

F. Health care records should not be marked to distinguish the HIV status of the offender.

G. Educational programs should be offered to the health care and correctional staff, as well as the offenders, regarding appropriate protection and other information regarding the disease. This may be in the form of written materials, videos, or through other related training courses.

H. Also refer to IS11-14.6, HIV Testing for Offenders.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-B-01 Infection Control Program – *essential;* P-H-02 Confidentiality of Health Records and Information – *essential.*
B. CMS Infection Control Manual
C. Missouri Department of Health Communicable Disease Manual
D. IS11-14.6 HIV Testing for Offenders

VI. HISTORY: This procedure was originally covered by IS11-14.4 HIV Infected Inmates Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date:

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-14.3 Communicable Disease Isolation

Effective Date: October 22, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

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I. **Purpose:** This procedure has been developed to ensure offenders with communicable diseases have health care needs met, while protecting other offenders and staff from infection.

A. **AUTHORITY:** 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Standard Precautions:** A combination of the major features of universal precautions (designed to reduce the risk of transmission of bloodborne pathogens) and body secretion isolation (designed to reduce the transmission of pathogens from moist body substances), applied to all patients receiving care, regardless of diagnosis or presumed infection status.

III. **PROCEDURES:**

A. Policies and procedures for isolation of communicable disease are outlined in the CMS Infection Control Manual and Missouri Department of Health Manual which guides the reporting, and recommendations for communicable disease treatment.

B. Offenders requiring respiratory isolation should be housed in a room with negative airflow or transferred to a facility that can provide required isolation.

C. Standard precautions/universal blood and body fluid precautions outlined in the CMS Infection Control Manual should be practiced by health care and correctional staff.

D. Communicable disease isolation issues and/or problems should be discussed at the MAC meeting.

E. Waste disposal should be handled as outlined in the CMS Infection Control Manual utilizing the contracted waste/biohazardous waste vendor.

IV. ATTACHMENTS

None

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-B-01 Infection Control Program - *essential.*
B. CMS Infection Control Manual
C. Missouri Department of Health Communicable Disease Manual

VI. HISTORY:

This procedure was originally covered by IS11-14.3 Communicable Disease Isolation Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date:

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DEPARTMENT OF CORRECTIONS
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OFFICE OF INSPECTOR GENERAL

Compliance Unit **M e m o r a n d u m**

DATE: March 17, 2004

TO: Institutional Services Policy and Procedure Manual Holders

FROM: Sheila A. Scott, Administrative Analyst III

SUBJECT: **IS11-14.2 Tuberculosis Control**

Attached is the procedure covering IS11-14.2 Tuberculosis Control. The procedure has been revised significantly and should be reviewed in its entirety. Section III.F. should be closely reviewed because it now includes the use of force when offenders refuse to be tested. This change was made as a result of a recent change in state statute.

Please review this procedure and place appropriately in your manual.

SAS:vf

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

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IS11-14.2 Tuberculosis Control Effective Date: April 19, 2004

Ralf J. Salke
Senior Regional Vice President

Elizabeth Conley, D.O.
Regional Medical Director

George A. Lombardi, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

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I. **Purpose:** This procedure has been developed to provide guidelines to ensure methods of surveillance, assessment, and containment of tuberculosis (TB) among offenders and staff of correctional facilities.

A. **AUTHORITY:** 217.175, 217.320, 191.659, RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. **DEFINITION:**

A. **Acid Fast Bacillus (AFB) Testing:** A method of staining bacteria during laboratory testing which assists in identifying tuberculosis bacteria.

B. **Active Tuberculosis Disease:** Tuberculosis infection as evidenced by presence of Mycobacterium Tuberculosis bacilli in sputum specimens or significant findings of tuberculosis on chest x-ray.

C. **Assessment:** An evaluation of an offender for the purpose of tuberculosis surveillance and the process of making such and evaluation in determining a course of surveillance, containment, and/or treatment.

D. **Booster Test:** Repeated tuberculin test done two 2 to four 4 weeks after the initial 0 millimeters test (negative).

E. **Close Contacts:** Persons who sleep, live, work, or otherwise share air through a common ventilation system (6-8 hours contact per day for several weeks). This may be offenders or staff.

F. **Containment:** Process for ensuring that tuberculosis transmission does not occur through appropriate diagnostic services and monitoring of treatment compliance.

G. **HIV: Human Immunodeficiency Virus:** The virus known to cause Acquired Immunodeficiency Disease Syndrome (AIDS).

H. **Immunocompromised:** Individuals in whom the immune system response is weakened by immunosuppressive drugs, radiation, malnutrition, or by some disease process (e.g., cancer).

I. **Induration:** A palpable area of hardened tissue in relation to skin testing.

J. **Infection Control Nurse: (TB Nurse/HIV/STD/etc):** Health service staff nurse at the institution assigned by the health services administrator to assist with the responsibility of implementing and coordinating the institutional health service infection control processes.

K. **Insignificant Reaction:** A skin test induration between 5 and 9 millimeters of a non-immunocompromised or no contact to active tuberculosis disease.

L. **MARS/Computerized Medical Record:** Medical Accountability Record System; Computerized Medical Record for recording/documentation of patient information.

M. **Positive Reaction:** A skin test induration of 10 mms or greater. If the individual is immunocompromised, has been a contact to active disease, or has a chest x-ray finding suggestive of previous tuberculosis infection, a skin test of 5-mms induration to 9-mms is significant. If the individual is HIV seropositive, a skin test of 1-mm to 4-mms induration and chest x-ray findings suggestive of tuberculosis infection is significant.

N. **Purified Protein Derivative (PPD):** The substance used in the intradermal Mantoux method of skin testing.

O. **Regional Infection Control Nurse:** The contracted professional staff member responsible for overseeing the implementation, process, and liaison of infection control for offender health services under department contract health service facilities, and to insure reporting requirements with the Department of Health, and regional reporting.

P. **Respiratory Isolation:** An area with separate ventilation to the outside, negative pressure in relation to adjacent areas that should have a minimum of 6 air exchanges per hour.

Q. **Surveillance:** Identification and reporting of all offenders and staff in the system/institution who are infected with tuberculosis.

R. **TB Nurse:** The medical unit nurse assigned to monitor the tuberculosis program.

S. **Two Step TB Testing:** The implanting of the second PPD test within a specified time period following the initial negative test performed at intake, Diagnostic Reception Centers.

III. PROCEDURES:

A. **Surveillance:**

1. Tuberculosis screening shall be performed on all offenders as outlined in the Missouri TB Control Manual from the Missouri Department of Health and documented in the medical records accountability system or on the Tuberculosis Screening form (Attachment A).

2. Exceptions would be those with documented significant PPD reactions measured in millimeters.

3. Extreme allergic reactions are rare and are the result of sensitivity to the tuberculin-testing product.

B. **Entrance/Intake Testing:**

1. Each offender will be assessed for symptoms of tuberculosis upon arrival to reception and diagnostic facilities.

2. Offenders reporting previous positive reactions must be questioned by a nurse regarding when and where the test was performed and the status of preventative therapy.

   a. The health care provider should be contacted to verify;

      1. the reaction in millimeters (mms),

      2. the status of preventative/treatment therapy, and

      3. the date and status of chest x-rays.

   b. If treatment is verified the nurse should;

      1. obtain a chest x-ray following a physician's order,

      2. interview for presence of TB signs and symptoms to be documented in medical accountability record system,

      3. document the date, millimeter reactions (mms), and dates of treatment in the medical accountability record system TB testing record and problem list, and

      4. complete an Authorization for Release of Confidential Offender Treatment Information (Attachment B) signed by the offender to request treatment records.

   c. If the reported treating health provider is unable to verify a previous positive millimeter reaction, the offender should be treated as though she/he has not had a previously positive PPD, to include entrance PPD testing.

   d. If the reported treating health provider is able to verify a previous positive PPD reaction in millimeters, but completion of the prophylactic therapy cannot be verified, then following consultation with the responsible physician, the offender should be placed into the appropriate chronic care clinic and evaluated for prophylactic treatment.

   e. The date and millimeter (mms) of the previously positive PPD reaction must be documented in the MARS TB testing record.

3. A two step TB test (PPD) should be performed on all newly received offenders at a diagnostic center within 2 working days.

   a. A nurse will administer an intradermal injection of 0.1 ml of purified protein derivative (PPD) containing 5 tuberculin units in the dorsum of the arm.

1. The test must be repeated immediately in a different site (scapula area) if the initial implant is not correct.

b. Maintain a record of the name of each offender who received a PPD to ensure timely reading of the PPD.

1. The MARS system should be utilized for scheduling at the time of implanting the PPD.

2. Each offender's PPD should be recorded on the appropriate form by the nurse to include a record of the manufacturer and lot number of the PPD solution.

3. Document information utilizing medical accountability record system.

c. A nurse will interpret PPD within 48-72 hours and document measurement in mms of induration in the medical record and on the TB log:

1. do not record negative or positive, list only the millimeters,

2. erythema may be noted but not measured,

3. if the offender has been released from incarceration prior to reading the PPD document the release in the medical accountability record system.

d. If the result of the first test is positive, the offender is considered infected with *M. Tuberculosis;*

e. If the first test is negative, a second test should be administered 7 days later.

f. A positive reaction to the second test at initial intake testing is considered a boosted reaction and is not considered a skin-test conversion.

g. If when reading the PPD the site appears to have been altered or manipulated by the offender (i.e., scratching, irritating, etc.) the offender may be retested on the scapula. An appropriate rationale will be documented in MARs following nursing consultation with the responsible physician.

h. The TB Isolation Needs Worksheet (Attachment C) and corresponding MARS protocol must be completed for all offenders with a positive and insignificant PPD reaction.

i. Offenders who have a negative, 0-millimeter reaction to the second test should be classified as uninfected.

j. In persons who have had a negative, 0 millimeter skin test result, a positive reaction to a subsequent test (other than stated in B. 3. g.) is considered a skin test conversion and is likely to represent a new infection.

k. The reception center health care staff should place copies of offender specific TB information not included in the hard copy medical record at the time of transfer in a separate envelope and send to the receiving institution marked to the attention of the health service administrator/infection control nurse.

4. All offenders shall receive educational handouts that explain tuberculosis and the testing procedures.

C. **Annual Testing:**

1. PPDs should be performed annually during the offender's birth month regardless of when the last PPD was done; or at any time deemed necessary by the medical authority.

   a. Administer intradermal injection of 0.1 ml of purified protein derivative containing 5 tuberculin units in the dorsum of the arm. The test must be repeated immediately in a different site (opposite arm or scapula area) if the initial implant is not correct.

   b. Maintain a record of the name of each offender who received a PPD to ensure timely reading of the TB test. The medical accountability record system should be used for scheduling at the time of planting the PPD. Each offender's PPD should be recorded on the appropriate form to include a record of the manufacturer and lot number of the PPD solution. Recording information utilizing MARS/computerized medical record.

   c. When reading the TB test: If the site appears to have been altered or manipulated by the offender (i.e., scratching, irritating, et.) the offender may be re-tested on the scapula with appropriate rationale documented in MARS following nursing consultation with the responsible physician.

   d. The TB Isolation Needs Worksheet and corresponding MARS protocol will be completed for all offenders with a positive and insignificant PPD reaction.

   e. In persons who have had a negative 0-millimeter skin test result, a positive reaction to a subsequent test (other than stated in B. 3. f.) is considered a skin test conversion and is likely to represent a new infection.

2. At the time of testing offenders should be counseled by health care staff regarding the signs and symptoms of tuberculosis utilizing the Tuberculosis Screening form and offered educational handouts that explain tuberculosis and testing procedures.

3. PPDs should be performed on documented close contacts of those with active tuberculosis disease.

   a. This testing should occur when active disease has been confirmed and again 90 days following confirmation.

4. All offenders known to be immunocompromised should receive PPD testing and a chest x-ray at the time of diagnosis and annually thereafter during the offender's birth month.

5. Offenders transferred to another institution should receive a PPD as part of the transfer receiving screening process if they have not been tested within the previous year as documented in the medical record.

6. Offenders who have been diagnosed with bronchitis or pneumonia and whose symptoms fail to respond promptly after being placed on antibiotics should receive PPD testing and sputum collection for AFB smear and culture.

7. All offenders shall be interviewed and evaluated utilizing the TB Isolation Needs

Worksheet.

a. Offenders who meet the set threshold shall be isolated until active TB can be ruled out.

D. Staff Education:

1. It will be the responsibility of the health services administrator/designee to ensure that **all** nursing staff has participated in training on PPD test administration and reading during their orientation, with additional training as deemed necessary.

   a. This should be documented in the employee's file and reported to the regional infection control nurse.

2. Nursing staff should be able to perform both tasks (administration and reading of PPD tests.)

   a. The director of nursing/designee should monitor staff competency at these tasks.

E. Assessment:

1. Offenders with significant reactions should be interviewed immediately by health care staff concerning signs and symptoms of tuberculosis.

   a. The presence or absence of symptoms should be documented on the screening form.

   b. Offenders with insignificant reactions of (5mm to 9mm) must be retested in one month unless she/he has other risk factors or falls within the following groups;

      1. close contact of persons with infectious tuberculosis; or

      2. is immunocompromised which in these cases, a reaction of 5mm to 9mm will be considered significant.

   c. Offenders with symptoms of tuberculosis will be placed in respiratory isolation based upon their TB Isolation Needs Worksheet score.

      1. A chest x-ray should be performed within 48 hours of skin test reading or identification of symptoms.

      2. Offenders will use an N-95 mask during transport to a facility capable of respiratory isolation.

      3. Transporting staff and the receiving institution should also be informed of the offender's TB status so necessary precautions are taken.

   d. Symptomatic offenders should be placed on a medical hold at their current facility until follow-up testing is complete as provided in III.E. 1. b.

      1. The health services administrator/designee will notify classification regarding a need for a medical hold.

2. The regional medical director and regional infection control nurse should be notified by pager or phone of all cases suspected or confirmed cases of active tuberculosis disease.

2. Offenders with significant reactions should be interviewed immediately concerning signs and symptoms of tuberculosis.

   a. The presence or absence of symptoms should be documented on the screening form.

   b. HIV testing should be suggested, pre-test HIV counseling should be performed and an HIV anti-body test should be obtained.

   c. Asymptomatic individuals with significant PPD reactions should have chest x-rays performed within 3 workdays.

3. All offenders with significant reactions and abnormal chest x-rays, or who are symptomatic should immediately be transferred to a facility for respiratory isolation.

   a. Sputum evaluations initiated for possible tuberculosis to include AFB smears and culture.

   b. All sputums should be obtained in a properly ventilated area; one specimen each morning, until 3 adequate specimens have been obtained.

   c. All sputums should be obtained under the direct observation of a nurse to ensure specimen quality and/or quantity.

   d. Sputums should be obtained using either a negative airflow room or sputum induction chamber.

   e. If an offender is unable to produce quality sputum, a specimen may be induced through the use of a nebulizer treatment of D5W solution upon order by the responsible physician.

   f. Sputum specimens for AFB smear and culture should be sent to the Missouri State Tuberculosis Laboratory in Mt. Vernon, Missouri.

4. If the x-rays and/or sputum specimens are reported negative, the responsible physician, following established protocol, should determine further action.

5. Offenders may only be released from respiratory isolation after approval by the regional infection control nurse or regional/associate medical director.

F. Refusals:

1. When an offender refuses to comply with communicable disease testing or health treatment, the nurse should obtain a Refusal of Treatment form (Attachment D), and notify the responsible physician.

   a. The regional medical director and regional infection control nurse should be notified by pager or phone of all cases suspected or confirmed cases of active tuberculosis disease.

2. Offenders should receive counseling regarding the testing and treatment.

   a. Offenders should be allowed to reconsider their choice of refusing testing or medications.

   b. Offenders should also be made aware of the consequences of continued refusal including the use of force.

3. Offenders should be provided with counseling by health care staff regarding the importance of PPD testing prior to signing the Refusal of Treatment form.

   a. Documentation of the counseling will be entered into the computer Medical Accountability Record System.

   b. Upon receipt of the signed refusal the physician, health services administrator/director of nursing, and infection control nurse, and regional medical director must be notified.

4. Offenders will be given the Mantaoux Test "without the right of refusal" to comply with testing.

   a. The health services administrator/director of nursing should contact the appropriate security staff to assist with required PPD testing.

   b. All PPD testing requiring the use of force shall be documented and reported on the infection control monthly report as a forced PPD.

   c. IS20-3.1 Use of Force Guidelines and IS20-3.2 Use of Force Reporting will be followed.

   d. PPD testing requiring the use of force should be implanted on the scapula to decrease the possibility of altering/manipulation of the PPD site. All tests shall be read and documented per protocol, C.1.

5. If prophylactic treatment is indicated, but refused by the offender, procedures in III. F. 4. will be followed.

   a. The regional medical director/designee and regional infection control nurse will be notified by phone of any refusal of prophylactic treatment and or PPD testing Written documentation will follow.

   b. The regional medical director/regional infection control nurse should be notified of offenders who refuse to have a chest x-ray while being evaluated for active TB disease.

      1. These offenders may be forcibly x-rayed, using only such force as is necessary in accordance with IS20-3.1 Use of Force Guidelines to obtain a posterior-anterior chest radiograph.

      2. Only health staff shall perform the x-ray.

      3. Offenders will be enrolled in the infectious disease chronic care clinic and monitored quarterly at a minimum.

c. Offenders who do not comply with treatment for *active tuberculosis disease* must be transferred to a facility with an infirmary/transitional care unit appropriate for respiratory (AFB) isolation;

d. Legal counsels of the health care contractor and department of corrections will be notified of an offender's failure to comply with active disease treatment so that a determination can be made as to whether any further legal action is indicated or necessary.

e. Offenders who fail to comply with prophylactic treatment within one week should be counseled by the director of nursing/designee or facility health services infection control nurse.

1. Documentation of the counseling and the offender's refusal should be placed in the offender's medical record.

f. Offenders should be followed in the infectious disease chronic care clinic.

G. Case Reporting:

1. All completed tuberculosis screening forms which indicate tuberculosis infection should be reported to the regional medical director, regional infection control nurse, and the Missouri Department of Health utilizing the Tuberculin Testing Record form (Attachment E).

2. All offenders suspected of having active tuberculosis disease should immediately be reported to the regional medical director/designee.

3. All suspected or confirmed active diseases should be reported to the Missouri Department of Health using the Tuberculin Testing Record form and for confirmed active disease reported utilizing additional forms Disease Case Report form (Attachment F) and Tuberculosis History form (Attachment G) by the director of nursing or infection control nurse at the institution in which the offender is being isolated and to a member of the department's health services contract monitors.

a. The department's health services contract monitor shall notify the department's employee health coordinator.

b. A copy of the complete Tuberculosis Screening form should be sent to the regional medical director/designee and regional infection control nurse.

4. The Tuberculosis Infection Status form (Attachment H) should be sent to the institutional parole office notifying the staff of the offender's tuberculosis status.

H. Contact Investigation:

1. A list of close contacts should be obtained from the housing unit and work unit rosters and other sources as necessary.

a. The rosters consist of offenders and staff assigned or close contact through work assignment in same areas as the suspected active TB disease and cell mates, or associates that may not be identified in the above-listed groups.

2. Close contacts should receive baseline PPD testing, unless they have documented history of positive tuberculin test results recorded in millimeters, or have been tested within the last three months.

3. Close contacts should receive follow-up tuberculosis testing approximately 90 days after exposure.

4. All close contacts including those with previous positive results will be interviewed for signs and symptoms of tuberculosis and sign Annual Health Statement for Tuberculin Reactors - Offender(Attachment I) that symptoms have been reviewed or documented in the offender medical accountability record system by the health care staff.

I. Containment:

1. Offenders who are tuberculosis suspects should immediately be segregated until arrangements can be made for the offender to be placed in respiratory isolation at a designated infirmary/transitional care unit.

   a. The offender should wear a N-95 particulate respirator until placement in respiratory isolation.

2. If the sputum smears are positive for acid fast bacilli, the offender should be considered as having infectious tuberculosis and should be placed in respiratory isolation at a designated infirmary/transitional care unit.

   a. Treatment should be initiated as determined by the responsible physician per established protocol, and in consultation with the regional medical director as necessary.

   b. No offender should be released from respiratory isolation prior to receipt of 3 negative sputum smears or culture confirmation that the offender does not have *Mycobacterium tuberculosis* disease.

   c. The offender should remain in isolation until she/he provides 3 consecutive negative sputum smears and has been on appropriate therapy for a minimum of 2 weeks and has an improving chest radiograph and has an improving chest xray and demonstrates resolving symptoms.

   d. Other treatment issues should be determined by the physician following established protocol, and in consultation with the regional medical director.

   e. Each case needs be individually evaluated by the regional medical director/designee and regional infection control nurse prior to approval for release from respiratory isolation.

   f. No special precautions are needed for handling the offender's dishes, books, laundry, bedding, or other personal items.

   g. Any offender who is allowed outside isolation for any reason should be required to wear a N-95 particulate respirator.

3. All staff entering an AFB isolation room should wear a N-95 particulate respirator.

a. All health care staff responsible for caring for the suspected infectious offender must have documentation retained on-site in the employee's file of successful fit-test for the mask worn.

b. Persons with beards who cannot pass the fit test may need to be reassigned or shave their beards.

4. Prior to discharge from isolation, health staff shall complete the TB Isolation Needs Worksheet (Discharge Section).

a. Approval for release needs to be obtained from the regional infection control nurse or regional medical director/designee.

5. The following must be documented in the MARS medical file prior to discharge from isolation,

a. three (3) consecutive negative AFB cultures,

b. disappearance of cough,

c. weight gain if weight loss prior to isolation,

d. return of appetite,

e. afebrile/disappearance of fever, and

f. disappearance of night sweats.

J. Treatment:

1. All offenders with significant tuberculin reactions who do not have documentation of adequate treatment should be treated prophylactically regardless of age, unless there are medical contraindications.

2. All offenders with significant tuberculin reactions shall be enrolled and monitored in the infectious disease chronic care clinic for the duration of treatment.

a. All offenders with tuberculosis disease and/or infection should be given medication by directly observed therapy.

b. Prophylactic treatment should begin promptly once laboratory work and a chest x-ray are obtained and active disease has been ruled out.

c. Offenders on tuberculosis medications should be assessed by health care providers at least monthly for signs and symptoms of adverse reactions.

1. This assessment should be documented in the offender medical record.

2. Any offender with suspected side effects to medication should be referred to the responsible physician.

d. Monitoring for adverse reactions should include liver function tests as specified by treatment protocols.

1. These test results should be reviewed by a physician at each infectious disease follow-up.

e. The responsible physician and regional infection control nurse shall review each case prior to early discontinuance of treatment.

3. Offenders should receive a minimum of one tuberculosis teaching session provided by health care staff.

a. The Preventative Therapy Treatment handout should be read to the offender to fulfill this requirement (Attachment J).

b. Documentation shall be made in the offender computer medical record by the health care staff or by signature of the offender to the education session in the hard copy offender medical record.

4. Offenders for whom prophylactic treatment is not given should be counseled by the health care staff concerning the signs and symptoms of tuberculosis infection and should be instructed to report the onset of any symptoms promptly.

a. These offenders should be monitored in the infectious disease chronic care clinic and should receive an annual physician evaluation.

1. A chest x-ray should be completed whenever the offender complains of tuberculosis symptoms.

2. Offenders receiving treatment should receive documented counseling every three months by nursing staff.

3. Offenders for whom prophylactic treatment is not given should remain in a chronic care clinic for the duration of current or subsequent incarcerations.

b. Those offenders requiring a higher degree of medical monitoring should be housed at a designated facility with appropriate accommodations and trained staff.

1. The offender medical score should be re-evaluated, if necessary.

5. The Missouri Department of Health and the institutional parole officer should be notified when offenders who are on tuberculosis medications are released from incarceration.

a. Discharge plans for offenders on tuberculosis medication should be cleared through medical staff to facilitate contact with the health department in the community to which the offender will be going.

b. A 30-day supply of medication shall be given to the offender to avoid a break in her/his TB prophylactic treatment from the time of release to the scheduled health department appointment for follow-up.

c. The nursing staff shall contact the appropriate health department office and schedule a follow-up appointment for the offender.

1. The appointment scheduled should be made at the health department location designated for the area of the offender's residence.

d. The nursing staff shall notify the institutional parole officer in writing that the offender is on tuberculosis medication, the length of the treatment, and date of the follow-up appointment with the health department.

1. A copy of the document shall be placed in the offender's hard copy medical record.

IV. ATTACHMENTS

A.	931-3660	Tuberculosis Screening
B.	931-4197	Authorization for Release of Confidential Offender Treatment Information
C.	931-3942	TB Isolation Needs Worksheet
D.	931-1832	Refusal of Treatment
E.	580-1589	Tuberculin Testing Record
F.	580-0779	Disease Case Report
G.	580-1144	Tuberculosis History
H.	931-4014	Tuberculosis Infection Status
I.	931-4196	Annual Health Statement for Tuberculin Reactors - Offender
J.	931-3813	Preventative Therapy Treatment

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-B-01 Infection Control – *essential.*
B. CDC (Centers for Disease Control and Prevention) Morbidity/Mortality Weekly Report; June 7, 1996 "Prevention and Control of Tuberculosis in Correctional Facilities"
C. Missouri Department of Health, Tuberculosis Control Manual. Diagnosis/Treatment
D. CMS Infection Control Manual
E. IS11-1.8 Referral for Outside
F. IS11-14.6 HIV Testing for Offenders
G. IS11-71 Right to Refuse Treatment
H. IS20-3.1 Use of Force Guidelines
I. IS20-3.2 Use of Force Reports
J. IS21-1.1 Temporary Administrative Segregation Confinement

VI. HISTORY:

This procedure was originally covered by IS11-14.2, Refusal of Treatment located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: February 14, 1992

A.	Original Effective Date:	February 14, 1992
B.	Revised Effective Date:	March 1, 1992
C.	Revised Effective Date:	August 14, 1994
D.	Revised Effective Date:	August 28, 1996
E.	Revised Effective Date:	October 15, 1999
F.	Revised Effective Date:	April 19, 2004

ATTACHMENT A

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

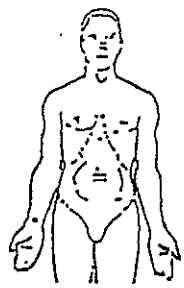
TUBERCULOSIS SCREENING

NAME	DOC NUMBER		TEST CODE
INSTITUTION	RACE	SEX	DOB

MEDICAL HISTORY

☐ Silicosis ☐ Positive TB Test ☐ Sero Positive HIV ☐ Cancer
☐ Immunosuppressant Therapy ☐ Diabetes ☐ Gastrectomy

If history of positive TB test but no documentation to confirm found, mark X by positive TB test (Even if history is questionable). Last PPD results, if hx positive PPD, are mm documented? Has inmate received follow up? CXR/AFB results? Past treatment dates documented?



SKIN TEST

DATE GIVEN	GIVEN BY	DATE READ	READ BY	RESULT

SYMPTOMS: (To be asked if PPD is read as > 5 mm including those with positive history of reactive skin test who have not been treated).

☐ Chronic cough (hangs on a long time) usually associated with sputum production
☐ Fever/Chills
☐ Unexplained weight loss
☐ Fatigue (feeling tired all the time)
☐ Spitting up blood
☐ Night Sweats
☐ Anorexia - Loss of appetite
☐ Weakness

CHEST X-RAY

DATE	RESULT (CHECK ONE) ☐ NORMAL ☐ ABNORMAL

X-RAY FINDINGS

SPUTUMS

	DATE OBTAINED	SMEAR RESULTS	CULTURE RESULTS
First			
Second			
Third			

Valid Smear Result Codes
0 - (negative)
1 - Positive (rare)
2 - Positive (few)
3 - Positive (many)
4 - Positive (numerous)

Valid Culture Result Codes
Organism:
Growth:
0 - Negative
1 - 5 Range of Positive

SMAC Drawn _____ HIV Drawn _____

TREATMENT STARTED (MM/DD/YR)

MEDICATION AND DURATION

INH	RIF	EMB	PZA	OTHER

☐ OLD POSITIVE ☐ NEW POSITIVE ☐ CONVERTOR ☐ CONTACT ☐ ENTRANCE ☐ ROUTINE

FORM COMPLETED BY	DATE HE/CD COORDINATOR NOTIFIED/BY WHOM

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

ATTACHMENT B

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL OFFENDER TREATMENT INFORMATION (FOR USE BY MEDICAL, MENTAL HEALTH AND SUBSTANCE ABUSE STAFF ONLY)

_____, # _____, _____, _____, allow and ask
(OFFENDER NAME) (DOC NUMBER) (DATE OF BIRTH) (SSN)

_____ to release my health records from services at the listed institution from _____
(INSTITUTION) (DATE)

to _____ to _____
(DATE) (PERSON, AGENCY, ORGANIZATION)

at _____.
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS INFORMATION RELEASE IS:

- ☐ PLACEMENT
- ☐ AFTERCARE
- ☐ TRANSFER
- ☐ TREATMENT PLANNING
- ☐ OTHER, SPECIFY _____

THE SPECIFIC INFORMATION TO BE DISCLOSED IS:

- ☐ ALL MEDICAL RECORDS WITHIN THE SPECIFIED TIME FRAME
- ☐ ALL MENTAL HEALTH RECORDS WITHIN THE SPECIFIED TIME FRAME
- ☐ ALL MEDICAL AND MENTAL HEALTH RECORDS WITHIN THE SPECIFIED TIME FRAME
- ☐ OTHER: _____

THIS AUTHORIZATION TO RELEASE HEALTH RECORDS IS SUBJECT TO THE FOLLOWING LIMITS: _____

_____

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ, UNDERSTAND AND ALLOW THIS CONSENT FOR THE FOLLOWING:

1. **READ CAREFULLY: I understand that my health records are private. I realize that by signing this consent, I am allowing my health records to be given to the agency or person listed above. Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization without limits, I am allowing the release of any drug and/or alcohol information records to the agency or person listed above.**
2. The release or transfer of information about my admission, condition or treatment with persons or agencies not listed above or by law and regulation is prohibited. I understand that this disclosure could result in a third party discovery.
3. This authorization includes both information already collected and information that would be collected during the course of the offender's treatment at the above facility during the specified time frame.

his consent starts on _____ (DATE) and can be cancelled by the undersigned any time by completing the notice of cancellation at the bottom of the page. Any action taken by this facility before the cancellation will not be affected.

5. This consent to release health information, unless cancelled earlier, will expire 90 days from the start date. **A photographic copy of this authorization is as valid as the original.**
6. I am allowing the release of information regarding HIV/AIDS status. ☐ YES ☐ NO
7. The facility, its employees, contracted employees, officers, and contracted physicians are released from legal responsibility or liability for the release of the health information that has been authorized for release.
8. Special conditions, dates, events, that would result in cancellation: _____

_____

9. I understand that I have the right to receive a copy of this authorization.

THE FOLLOWING APPLIES TO DRUG AND/OR ALCOHOL ABUSE TREATMENT INFORMATION RECORDS: Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation (42 CFR 2) prohibits you from making further discloser of it without the specific written consent of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

OFFENDER SIGNATURE	WITNESS SIGNATURE	PARENT/LEGAL GUARDIAN SIGNATURE
DATE	DATE	DATE

NOTICE OF CANCELLATION

I hereby cancel my authorization of this release of information regarding _____ (Offender Name) to the agency/person listed above. This cancellation effectively makes null and void any permission for release of information regarding admission, condition or treatment expressly given by the above authorization.

...NDER SIGNATURE	WITNESS SIGNATURE	PARENT/LEGAL GUARDIAN SIGNATURE
DATE	DATE	DATE

ATTACHMENT C

DEPARTMENT OF CORRECTIONS

TB ISOLATION NEEDS WORKSHEET

DOC NUMBER	DOB

INMATE NAME

If a patient has 4 points with some points from the respiratory column, she/he is to be immediately placed in Respiratory Isolation.
If a patient has 4 points with none from the respiratory column, she/he is to be placed in a single cell in the infirmary until further work-up.
If patient has 3 points, she/he is to get an **immediate, Chest X-ray** and be referred to physician for TB evaluation.

****Radiographic abnormalities that strongly suggest active TB include upper lobe infiltration, particularly if cavitation is seen, and patchy or nodular infiltrates in the apical or subapical posterior upper lobes or the superior segment of the lower lobe. If abnormalities are noted, or if the patient has symptoms suggestive of extrapulmonary TB, additional diagnostic tests should be conducted.**

****Close Air Contact to Disease - Remember to consider those inmates coming from jails.**

ADMISSION TO ISOLATION

RESPIRATORY SYMPTOMS			OTHER SYMPTOMS		
1. PPD Reading 10mms (Not Identified as Close Contact, or HIV Negative)	1 PT.		1. Normal CXR	0 PT.	
2. PPD Reading 5mms (Close Air Contact to Disease**, or HIV Positive)	1 PT.		2. Fever	1 PT.	
3. Abnormal CXR: Stable Calcified Granulomas	1 PT.		3. Night Sweats	1 PT.	
4. Abnormal CXR: Upper Lobe, Apical Infiltrates, etc.***	4 PT.		4. Significant Weight Loss (Unexplained)	1 PT.	
5. Productive Cough > 3 wks (immediate CXR)	3 PT.		5. Gastrectomy, Chemotherapy, 10% Underweight, Malabsorption Syndrome, Sarcoidosis, Diabetes, Long-term Immunosuppressive Therapy (> One Month or One Time High Dose)	1 PT.	
Bloody Sputum	4 PT.		6. HIV Positive	1 PT.	
Nonproductive Cough	2 PT.		7. History of Drug Abuse	1 PT.	
8. Recent Exposure to TB Disease	1 PT.				
9. Known Past PPD Positive	1 PT.				
10. On INH Prophylaxis Therapy	1 PT.				
11. On Anti-Tubercular Therapy Other Than INH	2 PT.		TOTAL POINTS THIS COLUMN		
TOTAL POINTS RESPIRATORY COLUMN			TOTAL POINTS OTHER COLUMN		

STAFF SIGNATURE DATE TOTAL OF BOTH COLUMNS

DISCHARGE FROM ISOLATION

If patient has 7 points, she/he may be discharged from isolation, provided an adequate written treatment plan is being followed.
*****Each case of drug resistant TB needs to be evaluated on an individual basis in regards to when the individual is ready for release from isolation.**

	POINTS AVAILABLE	SCORE GIVEN
1. 3 Consecutive Negative AFB Smears (On Adequate Sputum Specimens)	2 points	
2. Improvement of Symptoms (Without Being on Anti-TB Therapy Within 5 Days)	2 points	
3. Improving and Noncavitary Chest X-Ray	1 point	
4. 2 of the following: ☐ FEVER GONE ☐ NIGHT SWEATS GONE ☐ GAINING WEIGHT OR WEIGHT STABLE	1 point	
5. Improvement of Productive Cough to Nonproductive Cough	1 point	
6. No Cough	2 points	
7. 3 Consecutive Negative Cultures (On Adequate Sputum Specimens)	6 points	
HIV Negative	1 point	
Normal CXR	2 points	
10. Four Drug Therapy for 2-3 weeks	1 point	
STAFF SIGNATURE DATE	TOTAL POINTS	

ATTACHMENT D

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
REFUSAL OF TREATMENT

INSTITUTION

On this date, against medical advice, I am refusing the following treatment:

☐ 1. Medical care/treatment _____
MUST COMPLETE

☐ 2. Dental care/treatment _____
MUST COMPLETE

This treatment was offered and made available to me by the Department of Corrections/Correctional Medical Services.

My signature will verify that possible complications as a result of my refusal of such treatment have been fully explained to me. I hereby relieve the physicians, medical/dental staff and Department of Corrections of any and all responsibilities relative to this refusal of offered and available care/treatment.

INMATE'S NAME (PRINT OR TYPE)	DOC NUMBER	INMATE'S SIGNATURE	DATE
WITNESS	DATE	WITNESS	DATE

MO 931-1832 (8-96)

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
REFUSAL OF TREATMENT

INSTITUTION

On this date, against medical advice, I am refusing the following treatment:

☐ 1. Medical care/treatment _____
MUST COMPLETE

☐ 2. Dental care/treatment _____
MUST COMPLETE

This treatment was offered and made available to me by the Department of Corrections/Correctional Medical Services.

My signature will verify that possible complications as a result of my refusal of such treatment have been fully explained to me. I hereby relieve the physicians, medical/dental staff and Department of Corrections of any and all responsibilities relative to this refusal of offered and available care/treatment.

E'S NAME (PRINT OR TYPE)	DOC NUMBER	INMATE'S SIGNATURE	DATE
WITNESS	DATE	WITNESS	DATE

M ,OURI DEPARTMENT OF HEALTH

TUBERCULIN TESTING RECORD

A. PATIENT IDENTIFYING INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)

HOME TELEPHONE	WORK TELEPHONE	SOCIAL SECURITY NUMBER

ADDRESS

COUNTY	DATE OF BIRTH (MM/DD/YR)	SEX
		☐ MALE ☐ FEMALE

RACE
☐ WHITE ☐ BLACK ☐ AM. INDIAN OR ALASKAN NATIVE ☐ ASIAN OR PACIFIC ISLANDER

ETHNIC ORIGIN
☐ HISPANIC ☐ NOT HISPANIC

OCCUPATION

PLACE OF EMPLOYMENT

B. HISTORY OF TUBERCULIN TEST

HAVE YOU EVER HAD A BCG VACCINE?
☐ NO ☐ YES IF YES ▶ WHEN (MO/DAY/YR)

HAVE YOU EVER HAD A TUBERCULIN SKIN TEST? ☐ NO ☐ YES IF YES ▶	WHEN (MO/DAY/YR)	TYPE OF TEST

RESULTS IN mm OF PREVIOUS SKIN TEST

C. CURRENT TUBERCULIN PPD MANTOUX TEST(S)

DATE ADMINISTERED (MO/DAY/YR)	DATE READ (MO/DAY/YR)	RESULTS IN mm
DATE ADMINISTERED (MO/DAY/YR)	DATE READ (MO/DAY/YR)	RESULTS IN mm

D. ATTENDING HEALTH CARE PROVIDER

NAME

TELEPHONE NUMBER

REPORTED BY

NAME

FACILITY

ADDRESS

TELEPHONE NUMBER	DATE

E. REASON FOR TESTING

☐ CONTACT TO TB CASE ☐ EMPLOYMENT ☐ MEDICALLY REFERRED
☐ SYMPTOMATIC (PERSISTENT COUGH FOR MORE THAN 3 WEEKS, FEVER, NIGHT SWEATS, WEIGHT LOSS)
RESIDENT/EMPLOYEE OF ☐ LONG TERM CARE FACILITY ☐ DEPARTMENT OF CORRECTIONS
☐ HEALTH CARE FACILITY ☐ SUBSTANCE ABUSE CENTER ☐ SCHOOL/DAY CARE
☐ OTHER (COMMENT)

I CONSENT TO A TUBERCULIN SKIN TEST FOR THE ABOVE REASON(S). I UNDERSTAND I AM TO HAVE THE SKIN TEST READ IN 48-72 HOURS BY THE DESIGNATED READER/INTERPRETER.

CLIENT'S/GUARDIAN SIGNATURE ▶ DATE

F. X-RAY REFERRAL

CHEST X-RAY DONE ☐ NO ☐ YES ▶	DATE DONE	RESULTS ☐ NORMAL ☐ ABNORMAL FINDINGS

G. TREATMENT/RECOMMENDATIONS

☐ TUBERCULIN TEST POSITIVE
- ☐ PREVENTIVE DRUG THERAPY TO BE INITIATED
- ☐ PATIENT REFUSES PREVENTIVE THERAPY
- ☐ NO FURTHER ACTION NEEDED - REASON: _____

☐ TUBERCULIN TEST NEGATIVE
- ☐ PREVENTIVE DRUG THERAPY TO BE INITIATED
- ☐ NO FURTHER ACTION NEEDED
- ☐ FURTHER SUPERVISION RECOMMENDED

PREVENTIVE THERAPY ORDERED FOR _____ MONTHS STARTING (MO/DAY/YR):

MEDICATION AND DAILY DOSAGE:

INH (DAILY DOSAGE)	OTHER (DAILY DOSAGE)	OR INH (2 OR 3 x WEEKLY)	OTHER (2 OR 3 x WEEKLY)

MEDICATION PROVIDED BY: ☐ HEALTH DEPARTMENT ☐ PRIVATE PROVIDER

H. RISK FACTORS

MISSOURI DEPARTMENT OF HEALTH RECOMMENDATIONS FOR FOLLOW-UP AND PREVENTIVE TREATMENT — (CHECK APPROPRIATE RISK FACTOR(S)):

≥ 5
1. ☐ CONTACT TO TB CASE
2. ☐ IMMUNOSUPPRESSED PERSON (e.g., IMMUNOSUPPRESSIVE THERAPY, HIV INFECTION OR MALIGNANCY)
3. ☐ ABNORMAL CHEST X-RAY (i.e., OLD HEALED TB)

≥ 10
1. ☐ FOREIGN-BORN PERSON FROM AREAS WHERE TB IS COMMON
2. ☐ I.V. DRUG USER AND/OR ALCOHOLIC
3. ☐ RESIDENT OR EMPLOYEE OF CORRECTIONAL FACILITY, NURSING HOME, MENTAL INSTITUTION
4. ☐ CHILDREN YOUNGER THAN 4 YEARS OF AGE
5. ☐ HOMELESS OR MIGRANT WORKERS
6. ☐ MEDICALLY UNDERSERVED, LOW INCOME POPULATIONS
7. ☐ PERSON WITH DIABETES MELLITUS, POST-GASTRECTOMY, SILICOSIS, PROLONGED CORTICOSTEROID THERAPY OR 10% OR MORE BELOW IDEAL BODY WEIGHT
8. ☐ PERSONS WHO PROVIDE HEALTH CARE SERVICES OR TEACH HIGH-RISK GROUPS
9. ☐ SKIN TEST CONVERTER WITHIN 2 YEARS

COMMENTS: _____

ATTACHMENT E FRONT

PREVENTIVE EATMENT MONITORING — CONTINUATION

PATIENT'S NAME			DOB		Note: 6 months preventive treatment is recommended for all infected persons except for HIV positive individuals (12 months) and children (9 months).							
DATE OF CLINIC VISIT/DRUG PICKUP												
DATE OF NEXT VISIT												
INH _____ mg Rx#												
(Other) _____ mg Rx#												
Vitamin B6 _____ mg Rx#												
Liver Enzyme Collected (Y or N)												
Allergies (Y or N)												
ADVERSE EFFECTS: (Y or N)												
Fatigue, Weakness												
Fever, Chills												
Loss of Appetite												
Nausea												
Vomiting												
Jaundice												
Dark Brown Urine												
Rash, Itching												
Joint Pain												
Other Symptoms												
TAKING ANY OTHER DRUGS:? (List)												
COMMENTS:												
(For additional comments, please use "Continuation"												
section or Progress Notes - N-3A)												
C.H.N. SIGNATURE — SIGNATURE												

COMPLETION OF TREATMENT

TREATMENT COMPLETED (MONTH/DAY/YEAR)

TREATMENT STOPPED (MONTH/DAY/YEAR)

REASON TREATMENT STOPPED

- ☐ COMPLETED TREATMENT
- ☐ LOST, UNABLE TO LOCATE
- ☐ DIED
- ☐ MOVED/RECORDS REFERRED
- ☐ DISCONTINUED DUE TO ADVERSE REACTIONS (SPECIFY): _____
- ☐ OTHER (SPECIFY): _____

HEALTH CARE PROVIDER SIGNATURE

DATE

ATTACHMENT E BACK

MO 580-1589 (9-95)

PLEASE SEND TO YOUR L HEALTH DEPARTMENT

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

DISEASE CASE REPORT

REPORT TO LOCAL PUBLIC HEALTH AGENCY

1 DATE OF REPORT	2 DATE RECEIVED BY LOCAL HEALTH AGENCY
___/___/___	___/___/___

3 NAME (LAST, FIRST, M.I.)	4 GENDER ☐ MALE ☐ FEMALE	5 DATE OF BIRTH ___/___/___	6 AGE	7 HISPANIC ☐ YES ☐ NO ☐ UNKNOWN

8 RACE (CHECK ALL THAT APPLY) ☐ BLACK ☐ ASIAN ☐ PACIFIC ISLANDER ☐ WHITE ☐ AMERICAN INDIAN ☐ UNKNOWN	9 PATIENT'S COUNTRY OF ORIGIN	10 DATE ARRIVED IN USA ___/___/___

11 ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	12 COUNTY OF RESIDENCE	13 TELEPHONE NUMBER ( )

14 PREGNANT ☐ YES (IF YES NUMBER OF WEEKS ____) ☐ NO ☐ UNKNOWN	15 PARENT OR GUARDIAN	16 RECENT TRAVEL OUTSIDE OF MISSOURI OR USA ☐ YES ☐ NO IF YES, WHERE	17 DATE OF RETURN ___/___/___

18 OCCUPATION	19 SCHOOL/DAY CARE/WORKPLACE ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)

20 WORK TELEPHONE NUMBER ( )	21 OTHER ASSOCIATED CASES ☐ YES ☐ NO ☐ UNKNOWN IS REPORT PART OF AN OUTBREAK ☐ YES ☐ NO ☐ UNKNOWN	22 TYPE OF COMPLAINT/OUTBREAK ☐ FOODBORNE ☐ WATERBORNE ☐ OTHER (SPECIFY)

23 WAS PATIENT HOSPITALIZED ☐ YES ☐ NO ☐ UNKNOWN	24 PATIENT RESIDE IN NURSING HOME ☐ YES ☐ NO ☐ UNKNOWN	25 PATIENT DIED OF THIS ILLNESS ☐ YES ☐ NO ☐ UNKNOWN

26 CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD):	PATIENT YES	PATIENT NO	PATIENT UNK	HHLD MEMBER YES	HHLD MEMBER NO	HHLD MEMBER UNK
IS A FOOD HANDLER						
ATTENDS OR WORKS AT A CHILD OR ADULT DAY CARE CENTER						
IS A HEALTH CARE WORKER						

27 NAME OF HOSPITAL/NURSING HOME	28 HOSPITAL/NURSING HOME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)

29 REPORTER NAME	30 TELEPHONE NUMBER ( )

31 REPORTER ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	32 TYPE OF REPORTER/SUBMITTER ☐ PHYSICIAN ☐ OUTPATIENT CLINIC ☐ PUBLIC HEALTH CLINIC ☐ HOSPITAL ☐ LABORATORY ☐ SCHOOL ☐ OTHER

33 ATTENDING PHYSICIAN/CLINIC NAME	ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)	34 TELEPHONE NUMBER ( )

35 DISEASE NAME(S)	36 ONSET DATE(S) ___/___/___ ___/___/___	37 DIAGNOSIS DATE(S) ___/___/___ ___/___/___	38 DISEASE STAGE/ RISK FACTOR	39 PREVIOUS DISEASE/STAGE	40 PREVIOUS DISEASE DATE(S) ___/___/___ ___/___/___

41 - DIAGNOSTICS

TEST DATE (MO/DAY/YR)	TYPE OF TEST	SPECIMEN TYPE	COLLECTION DATE (MO/DAY/YR)	QUALITATIVE/ QUANTITATIVE RESULTS	REFERENCE RANGE	LABORATORY NAME AND ADDRESS (INCLUDE STREET OR RFD, CITY, STATE, ZIP CODE)

42 - TREATMENTS

TREATED (Y/N/UNK)	REASON NOT TREATED	TYPE OF TREATMENT	DRUG	DOSAGE	TREATMENT DATE (MO/DAY/YR)	TREATMENT DURATION (IN DAYS)	PREVIOUS TREATMENT	PREVIOUS LOCATION (CITY, STATE)

43 - SYMPTOMS

SYMPTOM (IF APPLICABLE)	SYMPTOM SITE (IF APPLICABLE)	SYMPTOM ONSET DATE (MO/DAY/YR)	SYMPTOM DURATION (IN DAYS)

44 COMMENTS

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF COMMUNICABLE DISEASE PREVENTION
P.O. BOX 570
JEFFERSON CITY, MISSOURI 65102

TUBERCULOSIS HISTORY

CASE NAME	YEAR REPORTED

COUNTY	TELEPHONE WORK / HOME

IF FOREIGN BORN: Country of Origin _____ Month-Year Arrived in U.S.: _____

1. **CURRENT Tuberculosis Diagnosis (Check Appropriately):**

   a. **Site of Disease:** ☐ Pulmonary ☐ Extrapulmonary Specify _____

   b. **Mantoux PPD:** Date: _____ mm induration: _____

   c. **Initial Chest X-ray:** Date: _____ ☐ Normal ☐ Abnormal

   d. **Initial Bacteriology:** Date: _____
   Smear: ☐ Pos ☐ Neg ☐ Unk
   Culture: ☐ Pos ☐ Neg ☐ Pending ☐ Unk

   e. **Initial Drug Regimen Prescribed:** Date: _____
   Names of Drugs: ☐ INH ☐ RIF ☐ PZA ☐ EMB ☐ Sm
   ☐ Other (Specify) _____

2. **PREVIOUS History of Tuberculosis Infection: (If no previous history, go to #3 on the reverse side.)**

   a. **Patient Had A Previous Tuberculin Skin Test:**
   ☐ Yes ☐ No ☐ Unk (If no or unknown, go to #3 on the reverse side.)

   b. **Previous Tuberculin Skin Test Reaction:**
   Date: _____ mm induration: _____ Type of Test:
   Result Obtained From: ☐ Patient ☐ Medical Record ☐ Mantoux ☐ Multiple Puncture ☐ Unk

   c. **Name of Physician or Facility who Provided the Tuberculin Skin Test:**

NAME	TELEPHONE

   d. **Reason for Tuberculin Skin Test:** ☐ Contact ☐ Employment
   ☐ Other (Specify) _____

   e. **Chest X-ray:** Date: _____ Result: ☐ Normal ☐ Abnormal
   If Abnormal, then: ☐ Cavitary ☐ Noncavitary

   f. **Preventive Treatment Ordered?** ☐ Yes ☐ No

   g. **If No, Why Not?**
   ☐ Not Prescribed ☐ Prescribed, But Not Taken ☐ Patient Became Lost
   ☐ Adverse Reaction ☐ Patient Declined

   h. **If Yes, Number of Months Completed:** _____
   Name of Drugs Prescribed: ☐ INH ☐ Rif ☐ EMB ☐ Other (Specify) _____

   i. **Risk Factor for Being Placed on Preventive Therapy:**
   ☐ Contact ☐ Converter ☐ Healed Disease
   ☐ Special Medical Indications ☐ Infected, <35 ☐ Unk

   j. **If Less Than 12 Months Treatment, Why?**
   ☐ Moved, Unlocatable ☐ Against Medical Advice ☐ Medical Advice
   ☐ Other (Include Reason) _____

k. Name of Physician or Facility Who Provided Follow-up or Treatment:

NAME

3. Is There a History of Known Exposure to a TB Case? ☐ Yes ☐ No ☐ Unk
If so, Indicate Name of Source Case and Approximate Date of Diagnosis:

NAME | DATE

4. Does the Patient Have a History of or is Currently:

	Yes	No	Unk
a. Physically Disabled?	☐	☐	☐
b. Cognative Disabilities?	☐	☐	☐
c. Unable to Read or Understand Instructions?	☐	☐	☐
d. Suffering from a Psychiatric Condition Requiring Treatment?	☐	☐	☐
e. Excessive Alcohol Use Within Past Year?	☐	☐	☐
f. Non-injecting Drug Use Within Past Year?	☐	☐	☐
g. Injecting Drug Use Within Past Year?	☐	☐	☐
h. Homeless Within Past Year?	☐	☐	☐
i. Resident of Correctional Facility at Time of Diagnosis?	☐	☐	☐

If yes, 1 ☐ Federal Prison 3 ☐ Local Jail 5 ☐ Other Correctional Facility
2 ☐ State Prison 4 ☐ Juvenile Correctional Facility 9 ☐ Unknown

j. Resident of Long-Term Care Facility at Time of Diagnosis? ☐ ☐ ☐

If yes, 1 ☐ Nursing Home 4 ☐ Mental Health Residential Facility 6 ☐ Other Long-Term Care Facility
2 ☐ Hospital-Based Facility 5 ☐ Alcohol or Drug Treatment Facility 9 ☐ Unknown
3 ☐ Residential Facility

5. Occupation *(Check all that apply within the past 24 months):*
1 ☐ Health Care Worker 3 ☐ Migratory Agricultural Worker 5 ☐ Not Employed within Past 24 Months
2 ☐ Correctional Employee 4 ☐ Other Occupation 9 ☐ Unknown

6. HIV Status:
0 ☐ Negative 3 ☐ Refused 9 ☐ Unknown **If Positive, List:** CDC AIDS Patient No. ⌊ ⌋
1 ☐ Positive 4 ☐ Not Offered
2 ☐ Indeterminate 5 ☐ Test Done, Results Unknown State HIV/AIDS Patient No. ⌊ ⌋

If Positive, Based on: 1 ☐ Medical Documentation 2 ☐ Patient History 9 ☐ Unknown

Comments: _____

QUESTIONNAIRE COMPLETED BY | DATE

ADDRESS | TELEPHONE

RETURN TO ▶ MISSOURI DEPARTMENT OF HEALTH
BUREAU OF TUBERCULOSIS CONTROL
P.O. BOX 570
JEFFERSON CITY, MISSOURI 65102

OFFICE USE ONLY ▶ | CASE NO. | CASE ALLOWED ☐ YES ☐ NO | SOURCE CASE IN MO. ☐ YES ☐ NO

ATTACHMENT H

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
TUBERCULOSIS INFECTION STATUS

INSTITUTION			
TO	INSTITUTIONAL PAROLE OFFICE	**FROM**	INFECTION CONTROL NURSE
SUBJECT	TUBERCULOSIS INFECTION STATUS	INMATE NAME	DOC NUMBER

The above named inmate has recently been tested for tuberculosis and his/her test has been read as reactive or "positive". This is indicative that the inmate has been exposed to tuberculosis bacillus and at this time is considered infected.

We are in the process of diagnostic testing which will assist us in determining whether this inmate should be considered "contagious". Some portions of the workup could take six to eight weeks before completion. If not previously treated for tuberculosis infection, most infected individuals will be treated prophylactically with antibiotics for six to twelve months to prevent contracting active "contagious" disease.

Please check with Medical Unit prior to the release of this inmate so that a final determination can be made regarding a need for continued monitoring and/or treatment by the Department of Health.

Thank you for your assistance in ensuring continuity of care for this inmate upon his/her release.

MEDICAL STAFF SIGNATURE	DATE

MO 931-4014 (9-96) DISTRIBUTION: WHITE - INMATE MEDICAL FILE CANARY - INSTITUTIONAL PAROLE OFFICER

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
TUBERCULOSIS INFECTION STATUS

INSTITUTION			
TO	INSTITUTIONAL PAROLE OFFICE	**FROM**	INFECTION CONTROL NURSE
SUBJECT	TUBERCULOSIS INFECTION STATUS	INMATE NAME	DOC NUMBER

The above named inmate has recently been tested for tuberculosis and his/her test has been read as reactive or "positive". This is indicative that the inmate has been exposed to tuberculosis bacillus and at this time is considered infected.

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nk you for your assistance in ensuring continuity of care for this inmate upon his/her release.

MEDICAL STAFF SIGNATURE	DATE

ATTACHMENT I

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

ANNUAL HEALTH STATEMENT FOR TUBERCULIN REACTORS – OFFENDER

OFFENDER NAME		
DOC NUMBER		
RACE	GENDER ☐ M ☐ F	DOB

This statement is to determine that I DO NOT have symptoms consistent with pulmonary tuberculosis such as:

	DO	DO NOT
night sweats (waking up from sleep drenched in sweat)	☐	☐
unexplained fever (fever for several weeks, unrelated to a known illness)	☐	☐
chronic cough lasting longer than three weeks	☐	☐
smoker's cough that has changed	☐	☐
coughing up blood	☐	☐
feeling tired all the time and/or being really weak	☐	☐
unexplained weight loss	☐	☐

If none of these symptoms are present, a chest x-ray is not necessary.

HAVE YOU HAD RECENT CONTACT WITH SOMEONE WITH CONTAGIOUS TUBERCULOSIS?
☐ YES ☐ NO ☐ UNKNOWN

OFFENDER SIGNATURE	DATE
STAFF SIGNATURE	DATE

MO 931-4196 (8-99)

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

ANNUAL HEALTH STATEMENT FOR TUBERCULIN REACTORS – OFFENDER

OFFENDER NAME		
DOC NUMBER		
RACE	GENDER ☐ M ☐ F	DOB

This statement is to determine that I DO NOT have symptoms consistent with pulmonary tuberculosis such as:

	DO	DO NOT
night sweats (waking up from sleep drenched in sweat)	☐	☐
unexplained fever (fever for several weeks, unrelated to a known illness)	☐	☐
chronic cough lasting longer than three weeks	☐	☐
smoker's cough that has changed	☐	☐
coughing up blood	☐	☐
feeling tired all the time and/or being really weak	☐	☐
unexplained weight loss	☐	☐

If none of these symptoms are present, a chest x-ray is not necessary.

HAVE YOU HAD RECENT CONTACT WITH SOMEONE WITH CONTAGIOUS TUBERCULOSIS?
☐ YES ☐ NO ☐ UNKNOWN

OFFENDER SIGNATURE	DATE
STAFF SIGNATURE	DATE

MO 931-4196 (8-99)

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

PREVENTATIVE THERAPY TREATMENT

Inadequate or interrupted treatment for tuberculosis (TB) can lead to drug-resistant TB and transmission of infection. Therefore, after effective medications have begun, it is of utmost importance that the medication be taken until completion of therapy. Due to the frequent transfer of inmates between institutions, prompt action must be taken to assure drug therapy does not lapse for any reason.

Preventative therapy reduces the risk of developing TB in infected persons. Certain groups within the infected population are at greater risk of developing TB than others. Persons in these groups should be treated regardless of age. The current preventative therapy is 6-12 months of daily or twice weekly antibiotics, usually **Isoniazid** (INH). It is given under observation to guarantee compliance. Initial blood tests are done as a precautionary measure, and repeated routinely at 1 and 3 months. The skin test will always be positive, which indicates past infection.

Individuals on isoniazid should be aware of the following RARE adverse reactions:

1. Numbness or tingling of the hands or feet;
2. Symptoms of liver damage: Loss of appetite, nausea, vomiting, persistent dark urine, yellow skin, extreme tiredness, unexplained elevated temperature for 3 days.

If you develop the above symptoms while you are taking Isoniazid, report them immediately to the medical unit. Your blood may be checked to determine if it is the medication which is causing the symptoms and not some other condition, such as the flu. **DO NOT STOP TAKING THE MEDICATION UNTIL YOU ARE SEEN BY THE MEDICAL UNIT AND/OR INSTRUCTED TO DO SO.**

It is not uncommon to experience an upset stomach after taking Isoniazid on an empty stomach. If this occurs, eat before taking the medication.

NOTES:

A. 3 million people die annually from TB.
B. Individuals who skin test "positive" have a 10% risk of developing active TB.
C. There is no way to determine who will develop TB.
D. A highly effective treatment (cure) is available — Isoniazid (INH).

If you have any questions about TB or your medication to prevent TB, please do not hesitate to ask the medical staff.

INMATE SIGNATURE	DATE	WITNESS

DISTRIBUTION: **WHITE** - MEDICAL UNIT; **CANARY** - INMATE

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MISSOURI DEPARTMENT OF CORRECTIONS
INSTITUTIONAL SERVICES
POLICY AND PROCEDURE MANUAL

****

IS11-15 Environmental Health and Safety

Effective Date: January 23, 2006

Ralf J. Salke
Vice President of Operations

Elizabeth Conley, D.O.
Regional Medical Director

Terry Moore, Director
Division of Adult Institutions

Randee Kaiser, Director
Division of Offender Rehabilitative Services

****

I. Purpose: This procedure has been developed to ensure a safe and sanitary environment for the institutions is maintained.

A. **AUTHORITY:** 217.175, 217.320 RSMo, NCCHC Standards for Health Services in Prisons, 2003.

B. **APPLICABILITY:** All offenders and staff in a correctional center and institutional treatment center under the jurisdiction of the Division of Adult Institution or Division of Offender Rehabilitative Services. Standard Operating Procedure specific to provision of health services procedures at the institution should be developed by the health services administrator in consultation with the medical director, other professional health providers, and the superintendent/designee.

C. **SCOPE:** Nothing in this procedure is intended to give a protected liberty interest to any offender. This procedure is intended to guide staff actions.

II. DEFINITION:

None

III. PROCEDURES:

A. The health services administrator/designee should inspect the safety and sanitation of the health service areas on a monthly basis and document findings on the Safety Inspection Checklist (Attachment A).

B. Housing:

1. Each offender should be furnished with a single bed, clean mattress, pillow and case, sheets, blanket, and a locker or cabinet for the safe and orderly storage of personal property; adequate lighting and noise containment. Offender will be referred to appropriate procedure, IS22-1.1 Offender Authorized Personal Property.

2. There should be sufficient hand-washing sinks, soap, drinking fountains, showers, toilets, and accessible, with adequate water pressure which are clean and in good repair.

3. Hot water for showers should be thermostatically controlled at temperatures between 100 and 120 degrees.

C. Laundry:

1. Laundry services, should assure the availability of a sufficient supply of clean linen and clothing.

2. Each offender should be provided with a daily change of underwear and at least three clean changes of clothing, one clean change of bed linen, and three personal towels per week.

3. Laundry of infectious or parasite-infected material will be handled using standard precautions and appropriately bagged, labeled and processed.

D. Housekeeping:

1. The housekeeping program should identify what has to be cleaned, at what frequency, by whom, how it is to be cleaned, and who evaluated the cleaning effectiveness and with what frequency.

2. Sufficient and appropriate cleaning equipment and supplies, including water-soluble cleaning compounds, should be available for the housekeeping program.

3. Refuse, including hazardous waste, should be handled, stored, and disposed of in a safe and sanitary manner consistent with local, state, federal regulations and in accordance with D4-2.10 Hazardous Waste Handling and Storage and IS11-15.1 Disposal of Regulated Waste.

E. Pest Control:

1. A pest control program should control the insect and rodent population.

2. The pest control program should be in compliance with federal and state laws and in accordance with IS4-1.3, Vermin and Rodent Control.

F. Risk Exposures:

1. There should be a sufficient number of electrical outlets within the health care treatment work areas for the operation of equipment and appliances so that extension cords are used minimally in accordance with D4-2.1.A05, Electrical Equipment Wires and Other Components and D4-2.1. A07, Extension Cords.

2. Fire retardation equipment (e.g., chemical tanks, fire hoses, air packs) should be kept in working order, and regular inspections of this equipment in accordance with D4-2.1 Safety Standards.

3. Barber and beauty shops should be operated in conformance with applicable laws, rules, and regulations.

4. Work areas sharing a common passage with sensitive service areas (e.g., dietary, commissary, laundry, health services) should have self-closing doors that are kept closed when not in use.

5. Personal protective equipment (e.g., gloves, gowns, lab coats, face shields) should be available to all staff and offenders who potentially may be exposed to infectious, parasitic, or hazardous materials or objects.

G. Equipment Inspections:

1. Regular inspections and servicing, consistent with manufacturer specifications and state regulations, should be undertaken for all heavy equipment (e.g., utilities, water supply, sewers) to assure that all systems continue to function properly.

2. Facility ventilation systems, especially any negative pressure areas for the control of infectious disease, should be monitored regularly for air quality.

H. Safety:

1. All offenders and staff are entitled to a safe and sanitary environment.

2. Measures to ensure the safety of all who live, work, or visit within the facility should be undertaken as needed.

I. The health services administrator/designee should participate in the institutional monthly safety inspection rounds, at minimum related to;

1. offender housing areas,
2. laundry, housekeeping practices,
3. pest control measures,
4. risk exposure containment measures,
5. equipment inspection and maintenance reports, and
6. occupational and environment safety inspection reports/attend facility monthly safety meetings.

J. The site medical director should review institutional safety and food service inspection reports.

1. These reports should be reviewed during the medical audit committee meeting when health care issues or actions are needed to correct deficiencies.

K. The superintendent/designee should complete the Medical Unit Monthly Checklist (Attachment B).

1. The health services administrator will review and implement corrective action that may be indicated.

IV. ATTACHMENTS

A.	931-3814	Safety Inspection Checklist
B.	931-3858	Medical Unit Monthly Checklist

V. REFERENCES:

A. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003, P-B-02 Environmental Health and Safety – *essential.*
B. D4-2 Workplace Safety
C. D4-2.1 Health and Safety Program
D. IS4-1 Maintenance of Institutional Grounds and Buildings
E. IS4-1.1 Standard of Cleanliness
F. IS4-1.3 Vermin and Rodent Control
G. IS8-6.1 Access to Basic Hygiene Items
H. IS10-1.5 Safety and Accident
I. IS10-1.6 Sanitation Standards
J. IS10-1.7 Sanitation Inspections
K. IS10-1.16 Food Storage
L. IS10-1.19 Food Service Sample Tray
M. ISIS20-1.5 Inspections of Institutions
N. IS22-1.1 Offender Authorized Personal Property
O. IS22-2.1 State Property Issued to Offenders

VI. HISTORY:

This policy was originally covered by IS11-15.1, Environmental Health and Safety Procedure located in the Missouri Department of Corrections Institutional Services Policy and Procedures Manual; Original Rule Effective: August 15, 1994.

A. Original Effective Date: August 15, 1994

B. Revised Effective Date: October 15, 1999

C. Revised Effective Date: January 23, 2006

DEPARTMENT OF CORRECTIONS

ATTACHMENT B

MEDICAL UNIT MONTHLY CHECKLIST

Was a Medical Administrative Committee (MAC) meeting held this month? (NCCHC P-03) ☐ YES ☐ NO
Did you attend? ☐ YES ☐ NO
Comments:

2. Medical grievances this month are: (NCCHC P-13) ☐ UP ☐ DOWN
Was a particular theme noticed (i.e. late medication, not seen in a timely manner, etc)?
Comments:

3. Was the medication room secured? (NCCHC P-30) ☐ YES ☐ NO

4. Was the medical unit area clean and safe? (NCCHC P-15) ☐ YES ☐ NO
Comments:

5. How many hours a day is a security officer assigned to the medical unit? HOURS

6. Are inmate workers utilized only in custodial duties? (NCCHC P-25/ACA 3-4340) ☐ YES ☐ NO

7. Are inmate health encounters conducted in relative privacy? (NCCHC P-06) ☐ YES ☐ NO
Comments:

8. Are daily visits made to disciplinary segregation by medical staff? (NCCHC P-43) ☐ YES ☐ NO

9. Are administrative segregation visits made at least three times weekly? (NCCHC P-44) ☐ YES ☐ NO
Comments:

10. Are medical records secured in medical unit? ☐ YES ☐ NO
Comments:

Were you informed of medical problems (serious illness, medical parole requests) in a timely manner? ☐ YES ☐ NO
Comments:

12. Check one random syringe/instrument count sheet and verify that number matches the syringe/instrument count on hand. Is the count correct? ☐ YES ☐ NO
Comments:

Item Checked _____

13. Do your walks on the yard reflect an increase in medical complaints? ☐ YES ☐ NO
Comments:

14. Is there a prevailing subject in these complaints? ☐ YES ☐ NO
Comments:

15. Do the minutes of the custody staff monthly meeting reflect medical unit problems? ☐ YES ☐ NO
Comments:

16. How many outside consults/appointments were cancelled?
Why?

17. Additional comments or concerns:

SUPERINTENDENT'S SIGNATURE | DATE

MO 931-3858 (1-97) DISTRIBUTION: WHITE - MONTHLY REPORT CANARY - ASS'T DIRECTOR/HEALTH SERVICES PINK - MEDICAL UNIT ADMINISTRATOR GOLDENROD - FILE

ATTACHMENT A

STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

SAFETY INSPECTION CHECKLIST

SAFETY SUGGESTIONS	YES	NO	COMMENTS AND DEFICIENCIES NOTED AND ACTION REQUIRED	DATE CORRECTED
FLOORS ARE FREE FROM BREAKS, LOOSE TILES OR LINOLEUM, OR ANY OBSTRUCTION THAT MIGHT CAUSE PEOPLE TO STUMBLE OR FALL?				
EXIT SIGNS ARE LIT AND EGRESS ROUTES ARE POSTED?				
WARNING SIGNS ARE POSTED FOR RADIATION, ETC.?				
PASSAGEWAYS & HALLS ARE FREE OF BOXES OR OTHER ARTICLES BEING STORED?				
"NO SMOKING" SIGNS ARE POSTED?				
EMPLOYEES ARE OBSERVING "NO SMOKING" RESTICTIONS?				
RUBBISH, EMPTY CARTONS & PAPER ARE DISPOSED OF IMMEDIATELY?				
WET AREAS ARE BLOCKED OFF & A SIGN POSTED TO WARN PERSONS APPROACHING?				
FIRE EXTINGUISHERS ARE AVAILABLE AT STRATEGIC PLACES?				
EMPLOYEES ARE AWARE OF THE LOCATION OF THE EXTINGUISHER NEAREST THEM?				
FIRE EXTINGUISHER INSPECTIONS ARE CURRENT?				
EQUIPMENT, MATERIALS OR SUPPLIES ARE REMOVED WHEN THEY ARE NOT USED, OR BECOME OBSOLETE?				
ROUTINE INSPECTIONS OF EQUIPMENT ARE SCHEDULED FOR PROPER MAINTENANCE?				
X-RAY EQUIPMENT HAS BEEN INSPECTED?				
ELECTRICAL CORDS ARE IN GOOD CONDITION AND WITHOUT WORN PLACES?				
PLUMBING IS IN GOOD REPAIR, PREVENTING WATER SEEPAGE OR CONDENSATION THAT COULD CAUSE A WET OR SLIPPERY FLOOR?				
PROVISIONS ARE MADE FOR DISPOSAL OF BIOHAZARDOUS WASTE?				
NEEDLES & OTHER SHARP INSTRUMENTS ARE DISCARDED ONLY IN DESIGNATED CONTAINERS?				
REFRIGERATORS ARE CLEANED REGULARLY?				
MEDICINE, LAB, AND FOOD SPECIMENS ARE STORED SEPARATELY? SPECIMEN REFRIGERATOR MARKED BIOHAZARDOUS?				

MO 931-3814 (*

DISTRIBUTION: ORIGINAL - MEDICAL CANARY - FIRE & SAFETY OFFICER